TRAUMA CENTER DATA DICTIONARY

Los Angeles County

Emergency Medical Services Agency

Incorporating:
National Trauma Data Standards (NTDS) 2017 Admissions
Trauma Quality Improvement Program (TQIP)

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LOS ANGELES COUNTY TRAUMA DATABASE PATIENT INCLUSION

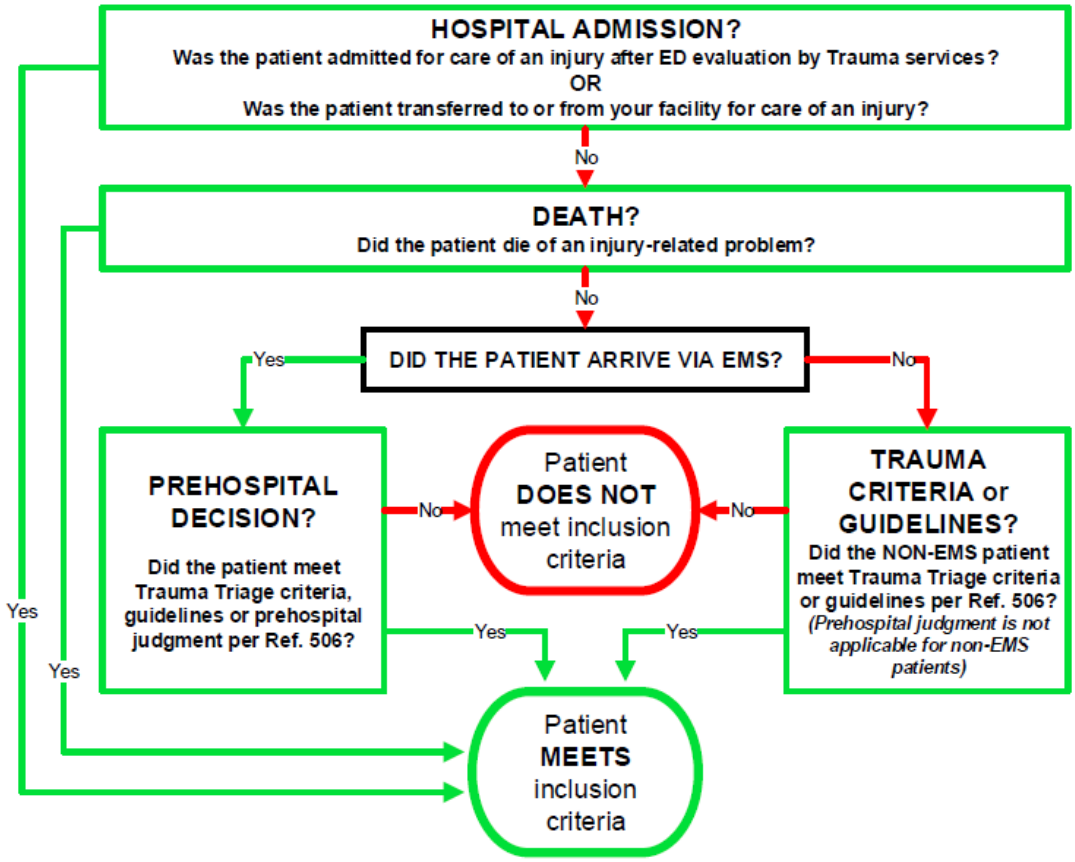
TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:
Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:
GROUND LEVEL FALLS:
resulting in isolated closed hip fractures in patients > 50 years of age; or
fractures of or distal to the knee or elbow in patients of any age
OR
burns; drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); and insect bites

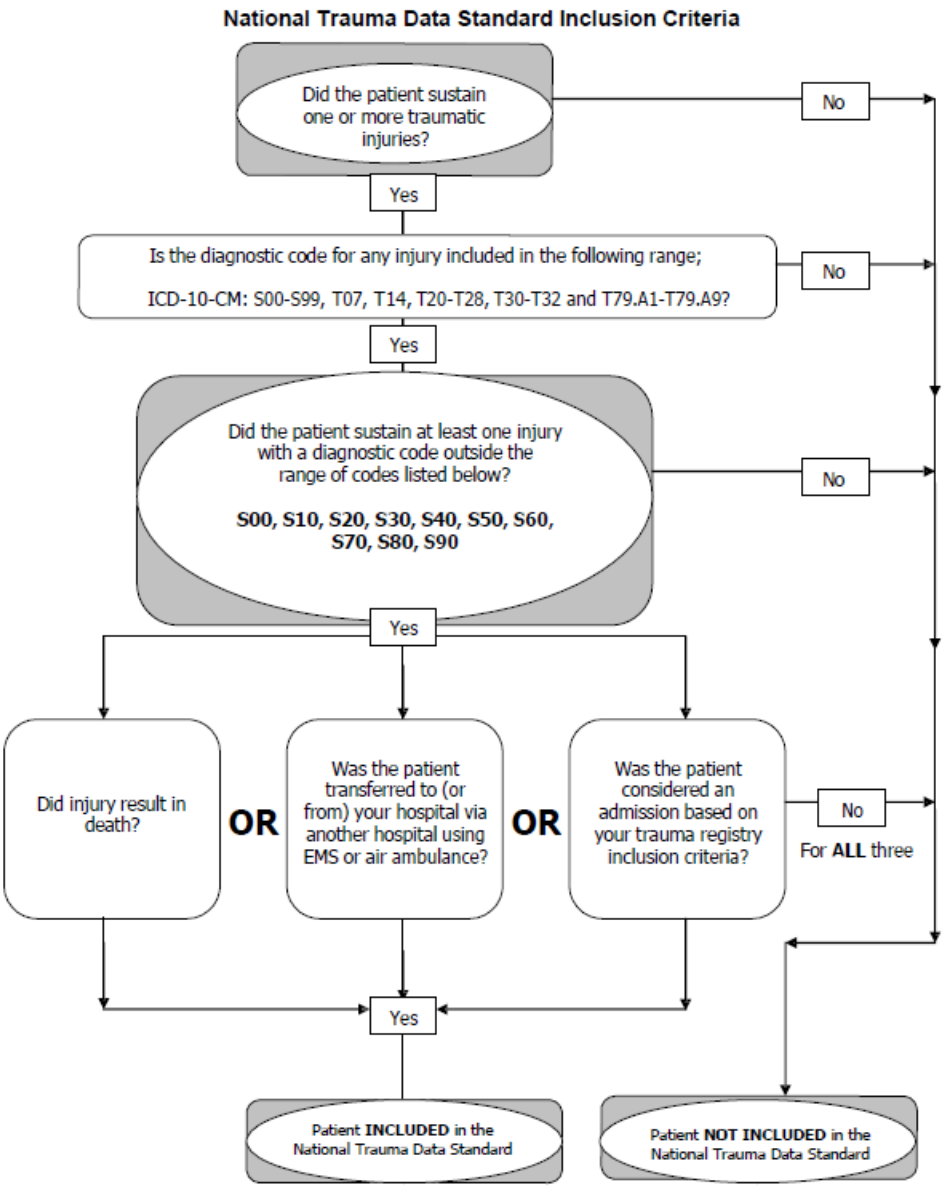
INCLUSIONS:
Patient has at least one ICD-10 injury diagnostic code within the range of S00-S99 & T79.A1-T79.A9



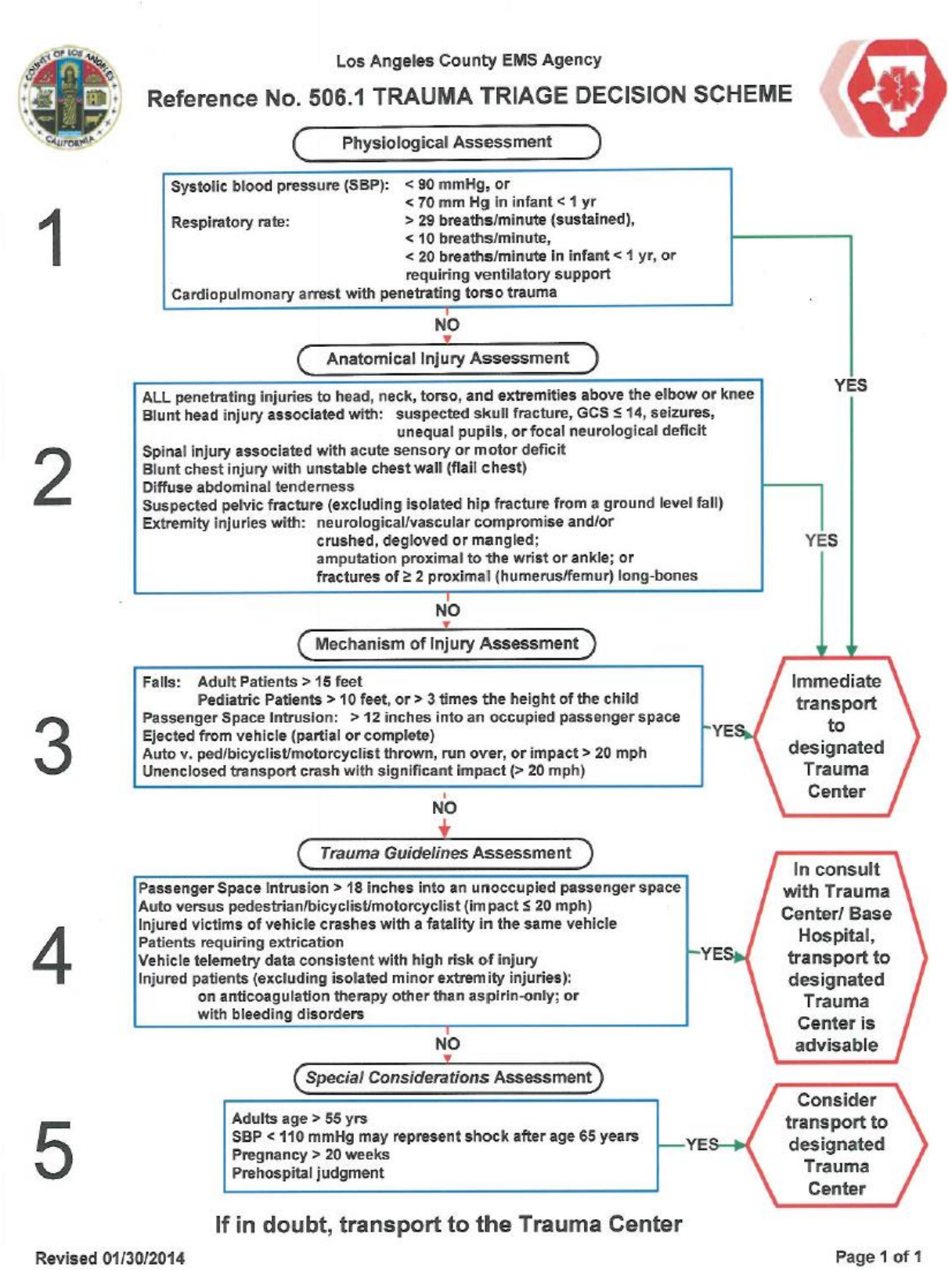
CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

July 1, 2016 (Implemented)
Valid until amended by the EMS Agency
(Replaces Exhibit C dated January 1, 2016)
Modified 09/20/2016

2017 NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA



Reference No. 506.1 TRAUMA TRIAGE DECISION SCHEME



TRAUMA PATIENT SUMMARY FORM (TPS) - Page 1

GENERAL INFO

LAST NAME	FIRST NAME	INITIAL	ARRIVAL DATE / /	ARRIVAL TIME ___:___

ADDRESS: ☐ Unknown ☐ Homeless

SEX: ☐ M ☐ F | **D.O.B.:** / / | **AGE:** ☐ YR ☐ MO ☐ DAY ☐ HR ☐ MIN ☐ ESTIMATE | **RACE/ETHNICITY:** ☐ Asian ☐ Black ☐ Filipino ☐ Hispanic ☐ Native American ☐ Pacific Islander, Other/Hawaiian ☐ Unknown ☐ White ☐ Other

ENTRY MODE: ☐ EMS ☐ NON-EMS
TRANSFER: ☐ ED to ED ☐ Direct Admit ☐ 9-1-1 Re-triage
VIA: ☐ Ground ☐ Air ☐ Vehicle ☐ Walk-in ☐ Police ☐ Other

EMS Form Available? ☐ Y ☐ N
Transferred From (TF): ___

SEQ #:
MR#:
OTH #:

TF Arrival Date: ___/___/___ **Time:** ___:___ **TF Exit Date:** ___/___/___ **Time:** ___:___

PREHOSP / WALK-INS

INJURY DATE __/__/__
INJURY TIME ___:___
PROVIDER _____
RA / SQUAD _____
DISPATCH DATE __/__/__
DISPATCH TIME ___:___
1ST ON SCENE ___:___
TRANSPORT ARR ___:___
TRANSPORT LEFT ___:___

INJURY DESCRIPTION: I I I ☐ Blunt
MECHANISM OF INJURY: I I I ☐ Penetrating

PROTECTIVE DEVICES:
☐ None ☐ Helmet
☐ Protective clothing
☐ Non-clothing gear
☐ Eye protection
☐ Personal Flotation Device
Airbag Deployed? ☐ Y ☐ N *(front)*
☐ Side ☐ Other *(curtain, knee, etc.)*
☐ Shoulder belt ☐ Lap belt
☐ Infant seat ☐ Child car seat
☐ Booster seat ☐ Other:_____

1st FIELD VS: BP____/____ HR_____ RR_____ O_2 SAT____%
1st FIELD GCS: E_____ V_____ M_____ TOTAL _____

EXTERNAL CAUSE CODE:

ADDITIONAL CAUSE CODE:

PLACE OF OCCURRENCE CODE:

INJURY ZIP CODE: *If unknown, must complete all known Address fields, i.e., City/County/State*

FIELD INTUBATION? ☐ Y ☐ N | **PREHOSPITAL CARDIAC ARREST?** ☐ Y ☐ N

WORK RELATED? ☐ Y ☐ N | **OCCUPATION:** | **INDUSTRY:**

EMERGENCY DEPARTMENT

ED NOTIFIED? ☐ Y ☐ N
ED ARRIVAL TIME ___:___
ACTIVATION? Y N
TIME: ___:___
LEVEL: _____
ED DISPO DATE __/__/__
ED DISPO TIME ___:___
ED EXIT DATE __/__/__
ED EXIT TIME ___:___

MET CRITERIA? ☐ Y ☐ N
HEIGHT: _____ ☐ INCH ☐ CENT | **WEIGHT:** _____ ☐ POUND ☐ KILO
1st ED VS: TIME ___:___ BP ____/____ HR _____ RR _____
ASST? ☐ Y ☐ N O_2 Sat _____% On O_2? ☐ Y ☐ N
TEMP: _____ ☐F ☐C TIME: _____:_____
GCS: E _____ V _____ M _____ TOTAL: _____
GCS *(Modifiers)*: ☐ **S**edated ☐ **E**ye obstruction ☐ **I**ntubated
TPS RATIONALE: ☐ Prehospital ☐ Non-EMS: Criteria/Guide ☐ Trauma Admission ☐ Trauma Transfer ☐ Died ☐ DHS=No

ADMITTING MD: | **ADMITTING SERVICE:**

MD SERVICE	MD CODE	REQUEST TIME	STAT?	ARRIVAL TIME
EMERGENCY PHYSICIAN (EDP)		:	Y N	:
TRAUMA SURGEON (TRS)		:	Y N	:
TRAUMA RESIDENT (TRR)		:	Y N	:
NEUROSURGEON (NES)		:	Y N	:
ORTHOPEDIC SURGEON (ORT)		:	Y N	:
ANESTHESIOLOGIST (ANE)		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:
		:	Y N	:

1st Antibiotic Administration (IF Blunt Open Tibial Fracture): **Date:** / / **Time:** _____:_____

IV FLUIDS in ED: _____mls | **ARRIVED WITH SIGNS OF LIFE?** ☐ Y ☐ N

DEATH IN ED: ☐ DOA (minimal/no resuscitations) ☐ <15min resuscitation ☐ Other death in ED

NEXT PHASE AFTER ED: ☐ <24hr ☐ OR ☐ ICU ☐ Ward ☐ Tele/Step ☐ Pediatric Ward ☐ Pediatric ICU ☐ Interventional Radiology ☐ Special Procedures ☐ Posthospital

CRITERIA MET:
☐ BP<90/70
☐ RR<10/>29/<20
☐ Suspected Pelvic Fx
☐ Spinal Injury
Penetrating:
☐ Arrest
☐ Head
☐ Face
☐ Neck
☐ Chest
☐ Abdomen
☐ Back
☐ Genitals
☐ Buttock
☐ Above Elbow or Knee
Blunt:
☐ Head w/GCS≤14
☐ Flail Chest
☐ Diffuse Abd. Tenderness
☐ ≥2 Long Bone Fxs
Extremity Injury:
☐ Neuro/Vascular/Mangled
☐ Amputation above Wrist or Ankle
MOI:
☐ Ejected
☐ PSI:12"
☐ Unencl. Vehicle >20mph
☐ Fall >15' (>10' pediatrics)
☐ Ped/Bike vs Auto >20mph
GUIDELINES MET:
☐ Extricated
☐ PSI:18"
☐ Ped/Bike vs Auto ≤20mph
☐ Survivor Fatal Accident
☐ Telemetry Data
☐ Anticoagulants
SPECIAL CONSIDER. MET:
☐ Pregnancy >20wks
☐ Age >55
☐ Age >65 with SBP <110
☐ **JUDGMENT** Prehospital

TRAUMA PATIENT SUMMARY FORM (TPS) - Page 2

NAME	ARRIVAL DATE / /	SEQ#	MR#	OTH #

RADIOLOGY / LABORATORY

X-RAYS

BODY PART	ICD-10	DATE	TIME	RESULTS
HEAD	BN00ZZZ	/	:	
NECK	BR00ZZZ	/	:	
CHEST	BW03ZZZ	/	:	
ABD	BW00ZZZ	/	:	
PELVIS	BR0CZZZ	/	:	
F.A.S.T	BW41ZZZ	/	:	

CT/ANGIO/MRI

BODY PART	ICD-10 w/out contrast	ICD-10 w/contrast	DATE	TIME	RESULTS
HEAD	BW28ZZZ	BW281ZZ	/	:	
NECK	BR20ZZZ	BR201ZZ	/	:	
CHEST	BW24ZZZ	BW241ZZ	/	:	
ABD	BW20ZZZ	BW201ZZ	/	:	
PELVIS	BW2GZZZ	BW2G1ZZ	/	:	

Comments / Results:

SOLID ORGAN INJURY? ☐ Y ☐ N

LIVER	Grade: I II III IV V VI
SPLEEN	Grade: I II III IV V
RIGHT KIDNEY	Grade: I II III IV V
LEFT KIDNEY	Grade: I II III IV V

GROUP/PANEL:	DATE	TIME	Result/Tested?
HGB / HCT	/	:	NML ABN
TOX (BLOOD)	/	:	T NT F NF
TOX (URINE)	/	:	T NT F NF
ETOH	/	:	T NT F NF

DRUGS OF ABUSE: ☐ Amphetamine ☐ Barbiturates ☐ Cannabinoids ☐ Cocaine ☐ Opiates ☐ PCP ☐ Other: _____

MTP ACTIVATED? ☐Y ☐ N | **TQIP Blood Inclusion?** ☐ Y ☐ N | **Lowest Systolic B/P:** W/in 1st hr. of arrival, IF PRBCs given w/in 1st 4 hrs.

BLOOD PRODUCTS:	PRBCs:	PLASMA (FFP):	PLATELETS:	CRYOPRECIPITATE:
Within 1st 4 hours	_____mls	_____mls	_____mls	_____mls
Within 1st 24 hours	_____mls	_____mls	_____mls	_____mls
TOTAL {includes ED}	_____mls	_____mls	_____mls	_____mls
Measurement	_____mls/unit	_____mls/unit	_____mls/unit	_____mls/unit
Conversion	_____mls	_____mls	_____mls	_____mls

PROCEDURES / OPERATIONS

ENTER ALL THAT APPLY DURING HOSPITAL STAY

PHASE	DATE	START @	END @	PROCEDURES *(ICD-10 Codes)*	PHASE	DATE	START @	END @	PROCEDURES *(ICD-10 Codes)*
	/	:	:	☐ ETT **0BH17EZ**		/	:	:	☐ ICP **4A103BD**
	/	:	:	☐ CRIC **0B110F4** (Open)		/	:	:	☐ JUG BULB
	/	:	:	☐ (L) CHEST TUBE **0W9B30Z**		/	:	:	☐ EVD
	/	:	:	☐ (R) CHEST TUBE **0W9930Z**		/	:	:	☐ IVC FILTER **06H03DZ**
	/	:	:	☐ THORACOTOMY **02JA0ZZ**		/	:	:	☐ TRACH **0BH10DZ** (Open)
	/	:	:	☐ DPA **0W9G3ZX**		/	:	:	☐ PEG **0DH63UZ**
	/	:	:	☐ CENTRAL LINE **05HY33Z** (Upper)		/	:	:	☐ VENTILATOR
	/	:	:	☐ CENTRAL LINE **06HY33Z** (Lower)	**TOTAL VENTILATOR DAYS** *(All Episodes)*:				

PHASE	DATE	CUT TIME	END TIME	PROCEDURES	ICD-10 CODE	SURG TYPE	MD CODE
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				

Angiograph:	Angiography Date: / /	Angiography Time: ___:___	Embolization Site:
Hemorrhage Control Type:	Hemorrhage Control Date: / /	Hemorrhage Control Time: ___:___	

PHASE AFTER OR: 1ST VISIT _____ 2ND VISIT _____ 3RD VISIT _____ 4TH VISIT _____ 5TH VISIT _____

TRAUMA PATIENT SUMMARY FORM (TPS) - Page 3

NAME	ARRIVAL DATE / /	SEQ#	MR#	OTH #

ICU / ACUTE CARE

ICU

ICU ARRIVAL DATE	ICU EXIT DATE
/ /	/ /
/ /	/ /
/ /	/ /
/ /	/ /
/ /	/ /

CONSULTS

CONSULT DATE	CONSULT SERVICE	MD CODE
/ /		
/ /		
/ /		
/ /		
/ /		

TQIP TBI Inclusion? ☐ Y ☐ N	Initial Pupillary Response: ☐ Both ☐ One ☐ Neither		
Highest GCS Total:	Highest GCS Motor:	Qualifier of Highest GCS:	
Midline Shift? ☐ Y ☐ N ☐ Not Imaged	Cerebral Monitor Type:	Date: / /	Time: :
TQIP VTE Prophylaxis Inclusion? ☐ Y ☐ N	VTE Prophylaxis Type:	Date: / /	Time: :
Withdrawal of Life Supporting Treatment? ☐ Y ☐ N		Date: / /	Time: :

POSTHOSPITAL

HOSPITAL DISPOSITION ORDER DATE: / / HOSPITAL DISPOSITION ORDER TIME: _____:_____

DISCHARGE DATE: / / DISCHARGE TIME: _____:_____ PRIOR PHASE:

TRANSFERRED / DISCHARGED TO: ☐ Acute Care ☐ AMA/Eloped/LWBS ☐ Burn Center ☐ Home w/Home Health ☐ Home w/o ☐ Hospice ☐ Jail ☐ Morgue ☐ Rehab ☐ SNF ☐ Sub Acute ☐ Trauma Center ☐ LTHC ☐ Psych ☐ Other

FACILITY: TRANSFERRED OUT VIA: ☐ Air ☐ Ground

TRANSFER RATIONALE: ☐ Health Plan ☐ Financial ☐ Specialized /Higher Level of Care ☐ Rehabilitation ☐ Extended Care ☐ In Custody ☐ Other: _____

DISCHARGE CAPACITY: ☐ Pre-Injury Capacity (Discharged from ED with minimum or no injuries) ☐ Temporary Handicap (Admit for injuries) ☐ Permanent Handicap, >1 year limitations (excludes splenectomy)

PHYSICAL ABUSE REPORTED? ☐ Y ☐ N INVESTIGATION INITIATED? ☐ Y ☐ N CAREGIVER CHANGE? ☐ Y ☐ N

☐ LIVED ☐ DIED AUTOPSY UPDATE? ☐ Y ☐ N CORONER #: _____ ☐ N/A

ORGAN REFERRAL? ☐ Y ☐ N ORGAN DONOR? ☐ Y ☐ N

ORGANS DONATED: ☐ Heart ☐ Intestine ☐ Kidney (1) ☐ Kidneys (2) ☐ Liver ☐ Lung (1) ☐ Lungs (2) ☐ Pancreas

DISCHARGE DIAGNOSES	ICD-10	AIS	DISCHARGE DIAGNOSES	ICD-10	AIS

NTDS CO-MORBID CONDITIONS: ☐ No NTDS Co-Morbidities ☐ Advanced Directive (limiting care) (DNR) ☐ Alcoholism ☐ Angina (Pectoris) ☐ Anticoagulant Therapy ☐ ADD/ADHD ☐ Bleeding Disorder ☐ CVA/Neuro Deficit ☐ Chemotherapy (currently receiving) ☐ COPD ☐ Cirrhosis ☐ Congenital Anomalies ☐ CHF ☐ Current Smoker ☐ Dementia ☐ Diabetes ☐ Dialysis (needs/on) ☐ Disseminated Cancer ☐ Drug (Substance) Abuse/Dependence ☐ Functionally Dependent Health Status ☐ HTN (requiring meds) ☐ Mental/Personality Disorder ☐ MI (w/in 6mons) ☐ Peripheral Arterial Disease (PAD) ☐ Prematurity ☐ Seizure Disorder ☐ Steroid Use ☐ Other:

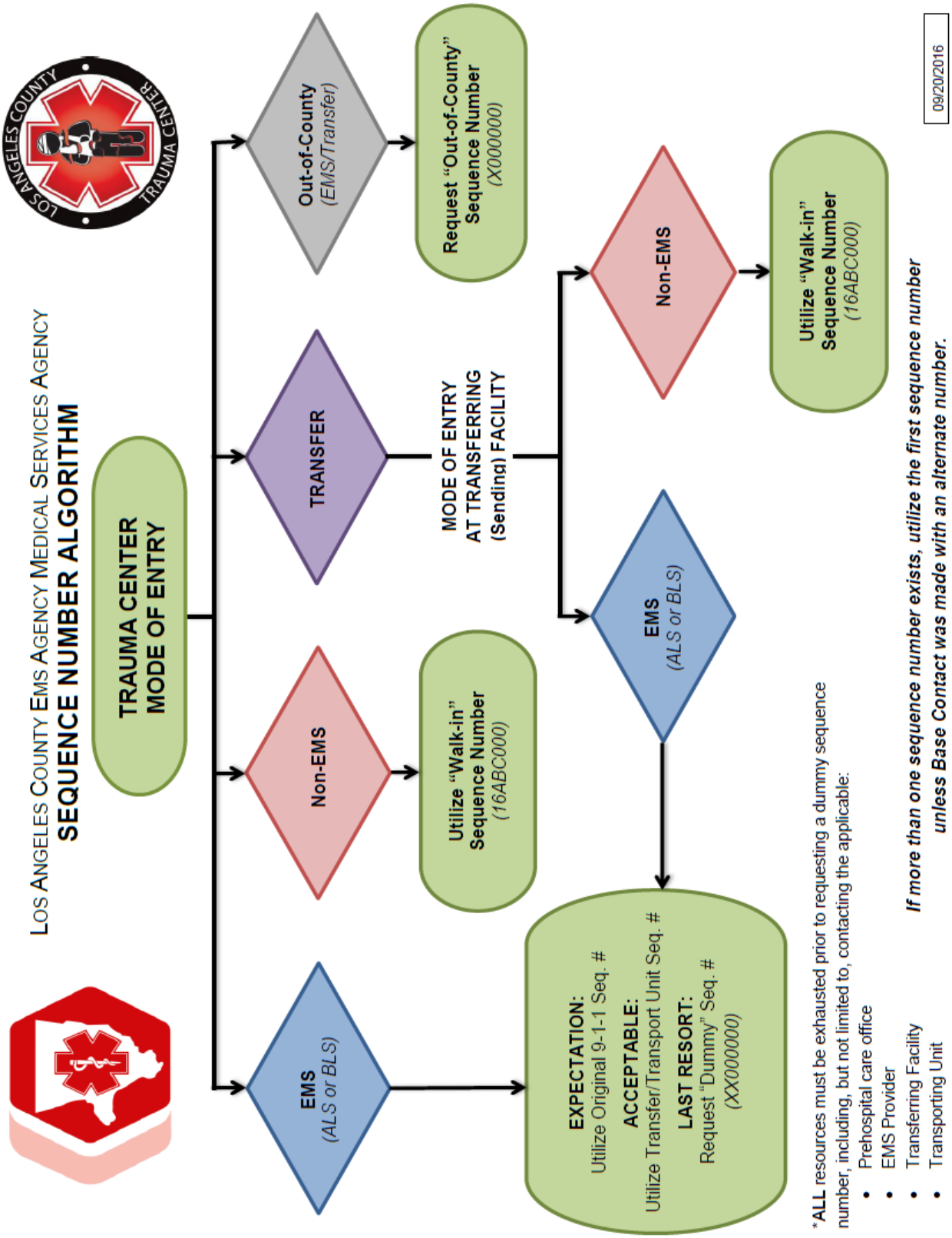
NTDS HOSPITAL COMPLICATIONS: ☐ No NTDS Hospital Complications ☐ Acute Kidney Injury (w/dialysis) ☐ ARDS ☐ Alcohol Withdrawal ☐ Cardiac Arrest w/CPR ☐ Central Line-Associated Blood Infection (CLABSI) ☐ CVA ☐ Decubitus (Pressure) Ulcer ☐ DVT ☐ Extremity Compartment Syndrome ☐ MI ☐ Osteomyelitis ☐ Pneumonia Ventilator Associated (VAP) ☐ PE ☐ Sepsis ☐ Surgical Site Infection: ☐ Superficial (Incisional) ☐ Deep ☐ Organ/Space ☐ Unplanned Intubation ☐ Unplanned Readmit ☐ Unplanned Return to the ICU ☐ Unplanned Return to the OR ☐ UTI Catheter Associated (CAUTI) ☐ Other:

FINANCES

Private/Commercial Insurance:	Government:	Self:	Medicaid:
☐ HMO	☐ CCS	☐ Cash	☐ Medi-Cal
☐ Medi-Cal HMO	☐ County Indigent	☐ ATP w/liability	☐ Medi-Cal pending
☐ Auto Insurance	☐ Custody Funds	☐ Pre-pay	☐ Medicare/Medicare HMO
☐ Worker's Comp.	☐ Military Insurance	**Not billed:**	
☐ Organ Donor Subsidy	☐ VOC (Victims of Crime)	☐ Charity	**TOTAL CHARGES:**
☐ Other private carrier:	☐ Other Government:	☐ ATP w/o liability	$

Revised 11/21/2016 #CP

SEQUENCE NUMBER ALGORITHM



MECHANISM OF INJURY REFERENCE GUIDE

Transportation Mechanisms of Injuries Quick Reference Guide

If patient is:	AND:	Then applicable MOI choices are:
STRUCK BY a moving transport, and NOT in an enclosed vehicle	Force is greater than 20mph, OR Patient is thrown, or run over by motorized transport	**RT** ***(and MM if applicable)***
	Force is less than 20mph	**PB** **SP** **CR*** **FA*** **OT** ***(and MM if applicable)***
OPERATING any transport	Transport is unenclosed, and force is GREATER than 20mph	**20** ***(and MM if applicable)***
	Transport is unenclosed, and force is LESS than 20mph	**SP** **MM** **CR*** **FA*** **OT**
	Transport is enclosed, regardless of speed	**EV** **EJ** **EX** **SP** **OT**

(*) - Rarely applicable in transport accidents.

ICD-9 defines a transport accident (E800-E848) as any accident involving a device/vehicle designed and used primarily for conveying persons or goods from one place to another. For the purposes of this policy, refer to the following examples.

MOTORIZED transports include, but are not limited to:	**UNENCLOSED** transports include, but are not limited to:
• Cars/Trucks • Vans • Buses • Planes • Trains • Motorcycles • Motorized bicycles (mopeds) • Motorized scooters • Golf carts	• Bicycles • Roller skates/blades • Skateboards • Non-motorized scooters • Non-motorized wheelchairs • Horses • Watercraft • ATVs

COMMON NULL VALUES

Definition

These values are to be used with each of the data elements described in this document which have been defined to accept the Null Values.

Field Values

- *Not Documented* (F6)
- *Not Applicable* (F7)

Additional Information

- **For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data.**
- *Not Documented (ND)*: This null value code applies if hospital documentation or an information system has an empty field or nothing is recorded. This null value signifies that the hospital patient care record provides a "placeholder" to document the specific data element, but that no value for that element was recorded for the patient. For example, a hospital patient care record may request date of birth, but the information was "*Not Documented"*.
- *Not Applicable (NA)*: This null value code applies if, at the time of patient care documentation, the information requested was "*Not Applicable*" to the patient, the hospitalization, or the patient care event. For example, variables documenting EMS care would be "*Not Applicable*" if a patient self-transports to the hospital.

FUNCTION AND HOT KEYS

Definition

These function and hot keys can be utilized at your discretion.

Field Values

FUNCTION KEYS		HOT KEYS	
F2	Enter the current date or time.	^C	Copy
F3	Enter last entered date or time.	^E	Close … (Report, Pathway, Page, etc.)
F4	Restore default value in selected field.	^I	Make new window copy.
F6	Not Documented.	^K	Run cross-checks for all fields in the current window.
F7	Not Applicable.	^L	List open windows.
F8	Calculate selected calculable field.	^M	Open note attached to selected field.
^F8	Calculate all calculable fields in the window.	^N	New … (Report, Pathway, Page, etc.)
F9	Clear selected field.	^O	Open … (Report, Pathway, Page, etc.)
F10	Set the current pathway and page to the user's defaults.	^P	Open picklist for selected field.
F11	Move to the next field group defined on the current window/page. Data Entry	^S	Save … (Report, Pathway, Page, etc.)
F11	Place non-leaf picklist item in selected field. Report/Population	^T	Display descriptive text for the code entered in the selective field. Data Entry
Shift + F11	Move to the previous field group defined on the current window/page. Data Entry	^U	Undo
F12	Return to parent.	^V	Paste
^PgUp	Go to previous page in pathway or in multiple-paged window.	^X	Cut
^PgDn	Go to next page in pathway or in in multiple-paged window.	ALT + Q	Quick exit from the system.

(^ Control Key)

SCROLLING WINDOWS COMMANDS

Definition

These commands can be utilized at your discretion.

Field Values

COMMANDS FOR SCROLLING WINDOWS	
PGUP	Move up a window full of items at a time in scrolling window and picklists.
PGDN	Move down a window full of items at a time in scrolling window and picklists.
^UP ARROW	Move out of scrolling window to previous item.
^DOWN ARROW	Move out of scrolling window to next item.
^A	Add new row to scrolling window.
^I	Insert new row above current row in scrolling window.
^D	Delete selected row in scrolling window.
^C	Copy selected row in scrolling window to the end of the scrolling window.
ALT+F9	Copy selected field value in scrolling window to the same field in successive rows having no values.
ALT+R	Resize scrolling windows and graphic boxes with arrows. (Valid only in Reconfiguration.)
^F	Go to first row in scrolling window.
^B	Go to last row in scrolling window.
SYSTEM-WIDE	
Single Click	Selects object.
Double Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist. On a title bar, minimizes the window.
Right Click	On an entry field, brings up associated picklist. On a picklist item, selects highlighted item or opens attached subpicklist.
ESC	Close open picklist, dialog window, or menu.

(^ Control Key)

GENERAL INFORMATION

DHS? YES / NO

Definition

The patient's TEMIS database inclusion status.

Field Values

- Y (Yes)
- N (No)

Additional Information

- "Yes" indicates that patient meets Exhibit C inclusion criteria.
- "No" indicates that patient does not meet Exhibit C inclusion criteria.
- If "No" is selected, TPS Rationale must be "DHS=No".
- DHS? YES / NO does not appear as a field value on the Trauma Patient Summary form.

Uses

- Allows facilities to capture data on patients not meeting Exhibit C inclusion criteria for their own purposes.
- "No" indicates that patient data will not be included in the LA County trauma database and will not be submitted to NTDB.

Other Associated Elements

- TPS RATIONALE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

TRAUMA CENTER CODE

Definition

Three-letter code for the trauma center submitting data.

Field Values

- Relevant value for data element

Additional Information

- Auto-populated as a read-only field – no user action necessary.
- TRAUMA CENTER CODE does not appear as a field value on the Trauma Patient Summary form.

Uses

- Identifies the treating facility.

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

LAST NAME

Definition

Patient's last name.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier.

Other Associated Elements

- FIRST NAME
- INIT

Data Format: [character, 25] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

FIRST NAME

Definition

Patient's first name.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier.

Other Associated Elements

- INIT
- LAST NAME

Data Format: [character, 12] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MIDDLE INITIAL

Definition

Patient's middle initial.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. ED Nurses Notes
3. Triage Form / Trauma Flow Sheet
4. EMS Report Form
5. Billing Sheet / Medical Records Coding Summary Sheet
6. ED Admission Form

Uses

- Patient identifier.

Other Associated Elements

- FIRST NAME
- LAST NAME

Data Format: [character, 1] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ARRIVAL DATE

Definition

The date the patient arrived in the ED or was admitted to the hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- If the patient was brought to the ED, enter the date patient arrived in the ED.
- If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Record
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of hospital stay.
- Used to calculate Total EMS Time (elapsed time from EMS Dispatch to Hospital Arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Other Associated Elements

- ARRIVAL TIME
- DISPATCH DATE / TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ARRIVAL TIME

Definition

The time the patient arrived to the ED / Hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- If the patient was brought to the ED, enter time patient arrived in the ED.
- If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Data entry of this field will auto-populate ED ARRIVAL TIME regardless of ENTRY MODE (ED ARRIVAL TIME will be auto-populated even if the patient is a Direct Admit).
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. EMS Report Form

Uses

- Allows data to be sorted based upon total length of hospital stay.
- Used to calculate Total EMS Time and Total Length of Hospital Stay.

Other Associated Elements

- ARRIVAL DATE
- DISPATCH DATE / TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE / TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

HOME ADDRESS

Definition

The house or building number of the patient's primary residence.

Field Values

- Relevant value for data element

Additional Information

- If the only address provided is a P.O. Box, enter in place of the Patient's Home Address.

Data Source Hierarchy

1. ED Records
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Patient identifier.

Other Associated Elements

- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME STREET

Definition

The street name of the patient's primary residence.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Patient identifier.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 40] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME STREET TYPE

Definition

The two-letter code for the street type of the patient's primary residence.

Field Values

LA COUNTY		
AL ALLEY	FY FREEWAY	PT POINT
AV AVENUE	GD GARDEN	RD ROAD
BL BOULEVARD	GN GLEN	RT ROUTE
CE CALLE	GR GROVE	SQ SQUARE
CA CANYON	HI HEIGHTS	ST STREET
CN CENTER	HY HIGHWAY	TR TERRACE
CH CHANNEL/CANAL	LN LANE	TT TRACK/TRANSITION
CL CIRCLE	LP LOOP	TL TRAIL
CO CORNER	MT MOUNT	TK TURNPIKE
CT COURT	MY MOTORWAY	VW VIEW
CK CREEK	PK PARK	VS VISTA
CR CRESCENT	PY PARKWAY	WK WALK
CS CROSSING	PS PASEO	WY WAY
DR DRIVE	PL PLACE	OT OTHER NOT LISTED
EX EXPRESSWAY	PZ PLAZA	

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Patient identifier.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME APT

Definition

The apartment number of the patient's primary residence.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Patient identifier.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME ZIP CODE

Definition

The patient's home ZIP code of primary residence.

Field Values

- Relevant value for data element

Additional Information

- Use 5-digit code (XXXXX).
- Data entry of a valid HOME ZIP CODE will auto-populate HOME CITY, HOME COUNTY, HOME STATE, and HOME COUNTRY.
- May require adherence to HIPAA regulations.
- Patients possessing an address, but which cannot be found on any document would have a ZIP CODE of "*Not Documented*".
- Patients not having a home, (or, therefore, a home address or ZIP code) the home address fields will not apply to that patient - so their home ZIP CODE will be "*Not Applicable".*
- ZIP CODE entered as "*Not Applicable*" will auto-populate all address related fields with "*Not Applicable*".
- If the only address provided is a P.O. Box, utilize the ZIP CODE for the P.O. Box.
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Used to calculate FIPS code.
- Allows data to be sorted based upon the geographic location of the patient's home.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 90001 (CA) **Max Value:** 96162 (CA) **Accepts Null Value:** Yes

ALTERNATE HOME RESIDENCE

Definition

One-letter code reason when home zip code is *“Not Applicable”*.

Field Values

- H Homeless
- U Undocumented
- M Migrant
- F Foreign Visitor

Additional Information

- Only complete when ZIP CODE is *"Not Applicable".*
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented Citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant Worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same country.
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. History and Physical
3. EMS Report Form

Uses

- Allows data to be sorted based upon type of residence.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME CITY

Definition

The patient's city (or township, or village) of primary residence.

Field Values

- Relevant value for data element

Additional Information

- Data entry of a valid HOME ZIP CODE will auto-populate the HOME CITY.
- Only complete when ZIP CODE is *"Not Documented"* or *"Not Known"*.
- ZIP CODE entered as "*Not Applicable*" will auto-populate all address related fields with "*Not Applicable*".
- IF the ZIP CODE entered doesn't match the PATIENT'S HOME CITY provided, manually override the information and enter the correct "PATIENT'S HOME CITY". Follow-up with Lancet representatives for identification of problem Zip Codes. Internally we will work towards a resolution of the issue with the specific Zip Codes identified.
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Used to calculate FIPS code.
- Allows data to be sorted based upon the geographic location of the patient's home.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME COUNTY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME COUNTY

Definition

The patient's county (or parish) of primary residence.

Field Values

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information

- Data entry of a valid HOME ZIP CODE will auto-populate the HOME COUNTY.
- Only complete when ZIP CODE is *"Not Documented"* or *"Not Known"*.
- ZIP CODE entered as "*Not Applicable*" will auto-populate all address related fields with "*Not Applicable*".
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Used to calculate FIPS code.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME STATE
- HOME COUNTRY

Data Format: [character, 15] single entry **Picklist:** Yes, modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME STATE

Definition

The two-letter code of the patient's state (territory, province, or District of Columbia) of primary residence.

Field Values

LA COUNTY		
AK Alaska	LA Louisiana	OR Oregon
AL Alabama	MA Massachusetts	PA Pennsylvania
AR Arkansas	MD Maryland	PR Puerto Rico
AS American Samoa	ME Maine	PW Palau
AZ Arizona	MH Marshall Islands	RI Rhode Island
CA California	MI Michigan	SC South Carolina
CO Colorado	MN Minnesota	SD South Dakota
CT Connecticut	MO Missouri	TN Tennessee
DC District of Columbia	MP Northern Mariana Islands	TX Texas
DE Delaware	MS Mississippi	UM US Minor Outlying Islands
FL Florida	MT Montana	UT Utah
FM Federated States of Micronesia	NC North Carolina	VA Virginia
GA Georgia	ND North Dakota	VI Virgin Islands of the US
GU Guam	NE Nebraska	VT Vermont
HI Hawaii	NH New Hampshire	WA Washington
IA Iowa	NJ New Jersey	WI Wisconsin
ID Idaho	NM New Mexico	WV West Virginia
IL Illinois	NV Nevada	WY Wyoming
IN Indiana	NY New York	OT Other
KS Kansas	OH Ohio	
KY Kentucky	OK Oklahoma	

Additional Information

- Data entry of a valid HOME ZIP CODE will auto-populate the HOME STATE.
- Only complete when ZIP CODE is *"Not Documented"* or *"Not Known"*.
- ZIP CODE entered as "*Not Applicable*" will auto-populate all address related fields with "*Not Applicable*".
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Used to calculate FIPS code.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- HOME CITY
- HOME COUNTY
- HOME COUNTRY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HOME COUNTRY

Definition

The patient's country of primary residence.

Field Values

- Auto-populated with USA – use picklist if needed for other countries

Additional Information

- Data entry of a valid HOME ZIP CODE will auto-populate the HOME COUNTRY.
- Only complete when ZIP CODE is *"Not Documented"* or *"Not Known"*.
- ZIP CODE entered as "*Not Applicable*" will auto-populate all address related fields with "*Not Applicable*".
- Data element cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Report Form

Uses

- Allows data to be sorted based upon the geographic location of the patient's home.
- Used to calculate FIPS code.

Other Associated Elements

- HOME ADDRESS
- HOME STREET
- HOME STREET TYPE
- HOME APT #
- HOME ZIP CODE
- ALTERNATE HOME RESIDENCE
- HOME CITY
- HOME COUNTY
- HOME STATE

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

SEX

Definition

The patient's gender.

Field Values

- M (Male)
- F (Female)
- U (Unknown)

Additional Information

- Patients who are undergoing, or have undergone, a hormonal and/or surgical sex reassignment should be coded using their stated preference.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. EMS Report Form

Uses

- Allows data to be sorted based upon gender.

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DATE OF BIRTH (DOB)

Definition

The patient's date of birth.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- If the patient is less than 24 hours old, complete variables: AGE and AGE UNITS.
- If "*Not Documented*", or "*Not Known*" complete variables: AGE and AGE UNITS.

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. Billing Sheet / Medical Records Coding Summary Sheet
5. EMS Report Form

Uses

- Used to calculate patient's age in days, months, or years.

Other Associated Elements

- AGE
- AGE UNITS

Data Format: [date] single entry **Picklist:** No
Min Value: Date minus 125yrs **Max Value:** Current date **Accepts Null Value:** Yes

AGE

Definition

The best approximation of patient's age at the time of injury when date of birth is unavailable.

Field Values

- Relevant value for data element

Additional Information

- If DATE OF BIRTH is entered, the AGE and AGE UNITS will be auto-populated.
- Entry required only when DATE OF BIRTH is less than 24 hours, "*Not Documented*", or "*Not Known*".
- If utilized, must also complete AGE UNITS field.

Data Source Hierarchy

1. Facesheet
2. ED Records
3. History and Physical
4. Billing Sheet / Medical Records Coding Summary Sheet
5. EMS Report Form

Uses

- Allows data to be sorted based upon age.

Other Associated Elements

- DATE OF BIRTH
- AGE UNITS

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: 1hr **Max Value:** 125yrs **Accepts Null Value:** Yes

AGE UNITS

Definition

The units used to document the best approximation of patient's Age at the time of injury when Date of Birth is unavailable.

Field Values

- Y (Years)
- M (Months)
- D (Days)
- H (Hours)
- I (Minutes)
- YE (Years Estimated)
- ME (Months Estimated)
- DE (Days Estimated)
- HE (Hours Estimated)

Additional Information

- If DATE OF BIRTH is entered, the AGE and AGE UNITS will be auto-populated.
- Entry required only when DATE OF BIRTH is less than 24 hours, "*Not Documented*", or "*Not Known*".
- If utilized, must also complete AGE field.
- For patients 2 years of age or older, use "Y".
- For patients 1 to 23 months of age, use "M".
- For patients 1 to 29 days old, use "D".
- For patients up to 23 hours old, use "H".

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Uses

- Allows data to be sorted based upon age.

Other Associated Elements

- DATE OF BIRTH
- AGE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PEDIATRIC / ADULT

Definition

The patient's status, adult versus pediatric, at the time of injury.

Field Values

- A (Adult)
- P (Pediatric)
- U (Unknown)

Additional Information

- Normally calculated from DATE OF BIRTH and auto-populated.
- PEDIATRIC / ADULT does not appear as a field value on the Trauma Patient Summary form.

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Uses

- Allows data to be sorted based upon age.

Other Associated Elements

- DATE OF BIRTH
- AGE
- AGE UNITS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RACE / ETHNICITY

Definition

The patient's race and/or ethnicity.

Field Values

LA COUNTY	NTDB	
Race/Ethnicity	**Race**	**Ethnicity**
A Asian	Asian	Not Hispanic or Latino
B Black	Black or African American	Not Hispanic or Latino
F Filipino	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino
H Hispanic/Latino	White	Hispanic or Latino
N Native American	American Indian	Not Hispanic or Latino
P Pacific Islander (Other)/Hawaiian	Native Hawaiian or Other Pacific Islander	Not Hispanic or Latino
U Unknown	Other Race	Not Hispanic or Latino
W White	White	Not Hispanic or Latino
O Other	Other Race	Not Hispanic or Latino

Additional Information

- Patient race/ethnicity should be based upon self-report or identified by a family member.
- Based upon the 2010 US Census Bureau.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. History and Physical

Uses

- Allows data to be sorted based upon race.

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ENTRY MODE

Definition

The patient's mode of transport to the treating facility.

Field Values

LA COUNTY	NTDB
EMS: Ground	TRANSPORT MODE (P_07): Ground Ambulance
EMS: Air	TRANSPORT MODE (P_07): Helicopter Ambulance
NON-EMS: Vehicle/Walk-in	TRANSPORT MODE (P_07): Private/Public Vehicle/Walk-in
NON-EMS: Police	TRANSPORT MODE (P_07): Police
NON-EMS: Other	TRANSPORT MODE (P_07): Other
TRANSFERRED: 9-1-1 Re-Triage / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: 9-1-1 Re-Triage / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
TRANSFERRED: ED to ED / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: ED to ED / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
TRANSFERRED: Direct Admit / Ground	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Ground Amb
TRANSFERRED: Direct Admit / Air	INTER-FACILITY TRANSFER (P_17): Yes; TRANSPORT MODE (P_07): Helicopter Ambulance
(Not Applicable in LA County)	TRANSPORT MODE (P_07): Fixed Wing Ambulance

Additional Information

- If ENTRY MODE is Non-EMS: EMS data fields will auto-populate with "*Not Applicable*", e.g. PROVIDER, RA/SQUAD, INJURY DESCRIPTION, MECHANISM OF INJURY, etc.
- "TRANSFERRED: 9-1-1 Re-Triage" is indicated when patient is transferred from the ED of an acute care facility emergently via 9-1-1 to the ED at your facility (Use Default Pathway for data entry).
- "TRANSFERRED: ED to ED" is indicated when patient is both transferred from the ED of an acute care facility and has an ED phase of care at your facility (Use Default Pathway for data entry).
- "TRANSFERRED: Direct Admit" is indicated when patient is transferred from an acute care facility to your facility as an inpatient. Excludes patients transferred from a private doctor's office, stand-alone ambulatory surgery center, or delivered to your hospital by a non-EMS transport (Use Direct Admit Pathway for data entry). Use of the Direct Admit Pathway will auto-populate ED specific data fields with *"Not Applicable"*.
- Field value cannot be *"Not Applicable"*.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be evaluated based on mode of transport and/or by presence of an inter-facility transfer.

Other Associated Elements

- TRANSFERRED FROM
- TRANS. FROM: Arrival Time
- TRANS. FROM: Exit Time

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

EMS FORM AVAILABLE?

Definition

Indicates whether a copy of the patient's EMS Report Form is available for abstraction.

Field Values

- Y (Yes)
- N (No)

Additional Information

- If ENTRY MODE is EMS, entering "No" for EMS FORM AVAILABLE? will auto-populate the following EMS Provider fields with "*Not Documented*":
  - PROVIDER
  - RA/SQUAD
  - TR DISP DATE
  - TR DISP TIME
  - 1st ON SCENE
  - TR ARRIVED
  - TR UNIT LEFT
  - 1st FIELD GCS Fields
  - FIELD INTUBATION?
  - 1st FIELD VS Fields

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be evaluated based on presence of an EMS Report Form.

Other Associated Elements

- ENTRY MODE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED FROM (TF)

Definition

Enter the EMS Agency's three-letter code for the hospital from which the patient was transferred to your facility.

Field Values

- Relevant value for data element

Additional Information

- Excludes non-EMS transports and patients transferred from a private doctor's office or stand-alone ambulatory surgery center.

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon type of transfer.

Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED FROM (TF): Arrival Date

Definition

If the patient is a 9-1-1 Re-triage, enter the date the patient arrived at the facility they are being transferred from.

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- ONLY applicable for 9-1-1 Re-triage patients.

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon type of transfer.

Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSFERRED FROM (TF): Arrival Time

Definition

If the patient is a 9-1-1 Re-triage, enter the time the patient arrived at the facility they are being transferred from.

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- ONLY applicable for 9-1-1 Re-triage patients.

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon type of transfer.

Other Associated Elements Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Exit Date
- TRANSFERRED FROM (TF): Exit Time

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANSFERRED FROM (TF): Exit Date

Definition

If the patient is a 9-1-1 Re-triage, enter the date the patient exited the facility they are being transferred from.

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- ONLY applicable for 9-1-1 Re-triage patients

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon type of transfer.

Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Time

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSFERRED FROM (TF): Exit Time

Definition

If the patient is a 9-1-1 Re-triage, enter the time the patient exited the facility they are being transferred from.

Collection Criterion

ONLY COLLECT ON 9-1-1 RE-TRIAGE PATIENTS.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- ONLY applicable for 9-1-1 Re-triage patients.

Data Source Hierarchy

4. ED Records
5. EMS Report Form
6. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon type of transfer.

Other Associated Elements

- ENTRY MODE
- TRANSFERRED FROM (TF)
- TRANSFERRED FROM (TF): Arrival Date
- TRANSFERRED FROM (TF): Arrival Time
- TRANSFERRED FROM (TF): Exit Date

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

SEQUENCE

Definition

The patient's Sequence Number (EMS record number), which is pre-printed on the EMS Report form.

Field Values

- Relevant value for data element

Additional Information

- EMS-generated SEQUENCE #s follow "Mod-9" formula: 2 letters, 6 numbers.
- Electronic Patient Care Record (ePCR) SEQUENCE #s utilize: EMS Provider's two-letter code, the last 2- digits of the year, and an additional 8-digits.
- NON-EMS patients (only valid when Entry Mode is not equal to "EMS") when a valid SEQUENCE # is not available utilize: last two digits of the current year, followed by the three-letter Trauma Center Code (of the first treating trauma facility), and the sequential non-EMS patient number, e.g. ***17USC001***.
- DHS = No patients without an existing SEQUENCE # utilize: last two digits of the current year, followed by the two-letter Trauma Log Code, plus the sequential DHS = No patient number, e.g. ***17TL0001***.
- Essential link between the EMS, Base and Trauma databases – **every effort should be made to collect this information from any available source**. If not obtainable by any means, a "dummy number" can be requested from the EMS Agency. Supporting documentation of collection efforts must be provided, along with other specified fields that will enable additional search for the patient's sequence number in the Base and/or EMS databases.
- For transferred patients, or patients with more than one SEQUENCE #, use the sequence number from the initial contact whenever possible.
- For patients arriving from outside of LA County, contact the EMS Agency to request an "Out of County" SEQUENCE #.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records

Uses

- Patient identifier.
- Essential link between the EMS, Base and Trauma databases.

Other Associated Elements

- MR #
- OTHER #

Data Format: [character, 12] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MEDICAL RECORD (MR)

Definition

The patient's medical (or financial) record number as assigned by the treating facility.

Field Values

- Relevant value for data element

Additional Information

- 15 characters, user-defined patient record identifier.

Data Source Hierarchy

1. Facesheet
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Patient identifier.

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

OTHER

Definition

Other medical record number as assigned by the treating facility.

Field Values

- Relevant value for data element – facility specific

Additional Information

- OPTIONAL FIELD: This field may be used at the discretion of each treating facility.

Data Source Hierarchy

1. Facesheet
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Patient identifier.

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PREHOSPITAL

INJURY DATE

Definition

The date the injury occurred.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Estimates of INJURY DATE should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. History and Physical

Uses

- Important to identify when the injury event started to better analyze resource utilization and outcomes.

Other Associated Elements

- INJURY TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

INJURY TIME

Definition

The time the injury occurred.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Estimates of INJURY TIME should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call time) should not be used.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. History and Physical

Uses

- Important to identify when the injury event started to better analyze resource utilization and outcomes.

Other Associated Elements

- INJURY DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PROVIDER

Definition

The two-letter code for the EMS provider primarily responsible for the patient's prehospital care.

Field Values

PUBLIC PROVIDERS					
AF	Arcadia Fire	DF	Downey Fire	PF	Pasadena Fire
AH	Alhambra Fire	ES	El Segundo Fire	RB	Redondo Beach Fire
AV	Avalon Fire	FS	U.S. Forest Service	SA	San Marino Fire
BA	Burbank Airport Fire	GL	Glendale Fire	SG	San Gabriel Fire
BF	Burbank Fire	HB	Hermosa Beach Fire	SI	Sierra Madre Fire
BH	Beverly Hills Fire	LB	Long Beach Fire	SM	Santa Monica Fire
CB	LA County Beaches	LH	La Habra Heights Fire	SP	South Pasadena Fire
CC	Culver City Fire	LV	La Verne Fire	SS	Santa Fe Springs Fire
CF	LA County Fire	MB	Manhattan Beach Fire	TF	Torrance Fire
CG	US Coast Guard	MF	Monrovia Fire	UF	Upland Fire
CI	LA City Fire	MO	Montebello Fire	VE	Ventura County Fire
CM	Compton Fire	MP	Monterey Park Fire	VF	Vernon Fire
CS	LA County Sheriff	OT	Other Provider	WC	West Covina Fire
PRIVATE PROVIDERS					
AA	American Professional	GC	Phoenix Ambulance	PE	Premier Medical Transport
AC	Americare Ambulance	GR	Gentle Ride Ambulance	PN	PRN Ambulance
AB	Ambulife Ambulance	GU	Guardian Ambulance	RE	REACH Air Medical Service
AE	Aegis Ambulance	IA	Ambulanz	RO	Rescue One Ambulance
AM	Adult Medical Transportation	LT	Liberty Ambulance	RR	Rescue Services (Medic-1)
AN	Antelope Ambulance	LE	Lifeline Ambulance	RY	Royalty Ambulance
AR	American Medical Response	LY	Lynch EMS Ambulance	SC	Schaefer Ambulance
AT	All Town Ambulance	MA	Mauran Ambulance	SO	Southern CA Ambulance
AU	AmbuServe/Shoreline Ambu.	MI	MedResponse	ST	Star Medical Transport
AW	AMWest Ambulance	ML	Med-Life Ambulance	SY	Symons Ambulance
CA	CARE Ambulance	MR	MedReach Ambulance	TR	Trinity Ambulance
EA	Emergency Ambulance	MS	Medi-Star Transport	UC	UCLA Emergency Services
EX	Explorer 1 Ambulance	MT	MedCoast Ambulance	WE	Westcoast Ambulance
FC	First Rescue Ambulance	MY	Mercy Air	WM	West Med/McCormick
FM	Firstmed Ambulance	OT	Other Provider		

Additional Information

- Non-picklisted – manually enter information exactly as it appears on the EMS Report Form.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS Provider.

Other Associated Elements

- RA/SQUAD

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RA / SQUAD

Definition

The alphanumeric apparatus code of the paramedic unit primarily responsible for the patient's prehospital care.

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – manually enter information exactly as it appears on the EMS Report Form.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS Provider and unit.

Other Associated Elements

- PROVIDER

Data Format: [character, 6] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISPATCH DATE

Definition

The date the unit *transporting to your hospital* was notified by dispatch.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital form, tapes or electronic records
3. ED Records

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

DISPATCH TIME

Definition

The time the unit *transporting to your hospital* was notified by dispatch.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH DATE
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ON SCENE

Definition

The time of arrival of the **first** EMS unit (ALS or BLS) on scene.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Indicates time prehospital EMS care began.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating total EMS scene time.

Other Associated Elements

- DISPATCH DATE/TIME
- TRANS ARR *(TRANSPORTING EMS UNIT ARRIVAL ON SCENE DATE/TIME)*
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE/TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANSPORT UNIT ARRIVAL DATE

Definition

The date the unit *transporting the patient to your hospital* arrived on scene.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Auto-calculated based on dispatch information – does not appear as a field on the TPS form or in the data entry program.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH DATE / TIME
- TRANS. LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE / TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSPORT UNIT ARRIVAL TIME

Definition

The time the unit *transporting the patient to your hospital* arrived on the scene.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH DATE / TIME
- TRANS LEFT *(TRANSPORTING EMS UNIT LEFT SCENE DATE / TIME)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TRANSPORT UNIT LEFT DATE

Definition

The date the *unit transporting the patient to your hospital* left the scene.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Auto-calculated based on Dispatch information – does not appear as a field on the TPS form or in the data entry program.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH DATE / TIME
- TRANS. ARRIV'D *(TRANSPORTING EMS UNIT ARRIVED SCENE DATE / TIME)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

TRANSPORT UNIT LEFT TIME

Definition

The time the unit *transporting the patient to your hospital* left the scene.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Allows data to be sorted based upon EMS Provider time intervals.
- Used in calculating EMS times.

Other Associated Elements

- DISPATCH DATE / TIME
- TRANS ARR (*TRANSPORTING EMS UNIT ARRIVAL ON SCENE TIME*)

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

INJURY DESCRIPTION

Definition

The LA County two-letter injury description code.

Field Values

BLUNT:	PENETRATING:	OTHER:
BL Blunt Minor Lac/Cont	PL Penetrating Minor Laceration	NA No Apparent Injury
BT Blunt Trauma Arrest	PT Penetrating Trauma Arrest	BU Burns / Electric Shock
BH Blunt Head	PH Penetrating Head	90 SBP <90, 70 SBP <1yr
14 BH with GCS ≤14		RR Respiratory Rate <10/>29, <20 if <1y
BF Blunt Facial/Dental	PF Penetrating Facial/Dental	
BN Blunt Neck	PN Penetrating Neck	
BB Blunt Back	PB Penetrating Back	SX Suspected Pelvic Fracture
BC Blunt Chest	PC Penetrating Chest	SC Spinal Cord Injury
FC Blunt Flail Chest		
BP Blunt Tension Pneumo	PP Penetrating Tension Pneumo	
BA Blunt Abdomen	PA Penetrating Abdomen	
BD Blunt Diffuse Tenderness		
BG Blunt Genitals	PG Penetrating Genitals	**IFT (Interfacility Transfer) Inpatient:**
BK Blunt Buttocks	PK Penetrating Buttocks	IT Inpatient Trauma (Direct Admit)
BE Blunt Extremity	PE Penetrating Extremity ↓ elbow/knee	
BR Blunt Fractures ≥ 2 long bone	PX Penetrating Extremity ↑ elbow/knee	
BI Blunt Amputation ↑ wrist/ankle	PI Penetrating Amputations ↑ wrist/ankle	
BV Blunt Neuro/Vasc/Mangled	PV Penetrating Neuro/Vasc/Mangled	

Additional Information

- If the patient has multiple injuries, enter the most significant injury first (most likely to be fatal).
- The INJURY DESCRIPTION should reflect the **injury force**, Blunt (MVA, Fall, Auto vs Ped) versus Penetrating (GSW or SW), selected.
- If the patient has an injury that fits multiple field values, e.g., Blunt Chest (BC) and Flail Chest (FC), Blunt Head (BH) and Blunt Head with GCS ≤14 (14), use the most significant injury. Flail Chest is a more significant injury than Blunt Chest, as is Blunt Head with GCS ≤14 more significant than Blunt Head.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records

Uses

- Allows data to be sorted based upon the injury description.

Other Associated Elements

- MECHANISM OF INJURY
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MECHANISM OF INJURY

Definition

The LA County two-letter code describing the mechanism of the patient's injury.

Field Values

LA COUNTY	
EV Enclosed Vehicle	AN Animal Bite
EJ Ejected	CR Crush
EX Extricated	TD Telemetry Data
12 Passenger Space Intrusion (PSI)	FA Fall
18 PSI >18 inch. into unoccupied passenger space	15 Fall >15Ft. Adult / >10Ft. Child
SF Survived Fatal Accident	SA Self Inflicted Accidental
20 Unenclosed Vehicle >20 MPH	SC Special Consideration
RT Ped/Bike Thrown / Runover >20 MPH	SI Self Inflicted Intentional
PB Ped/Bike ≤20 MPH	ES Electrical Shock
MM Motorcycle / Moped	TB Thermal Burn
SP Sports / Recreation	HE Hazmat Exposure
AS Assault	WR Work Related
ST Stabbing	UN Unknown
GS GSW	OT Other

Additional Information

- If the patient has more than one MECHANISM OF INJURY (MOI) use all that apply, e.g. Enclosed Vehicle (EV), Extrication Required (EX), and Passenger Space Intrusion (PS).
- Insect bites and bee stings are not considered animal bites, and should be coded as "Other" and do not meet the inclusion criteria for the trauma registry.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records

Uses

- Allows data to be sorted based upon the mechanism of injury.

Other Associated Elements

- INJURY DESCRIPTION
- BLUNT vs PENETRATING
- PROTECTIVE DEVICES

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

BLUNT vs PENETRATING

Definition

Injury type, blunt in which the tissues are not penetrated by an external object versus penetrating in which tissues are penetrated by single of multiple objects.

Field Values

- Blunt
- Penetrating

Additional Information

- If the patient has more than one type of injury, use the type of injury for the most significant injury, the injury most likely to cause prolonged disability or death.

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records

Uses

- Allows data to be sorted based upon the type of injury.

Other Associated Elements

- INJURY DESCRIPTION
- MECHANISM OF INJURY
- PROTECTIVE DEVICES

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PROTECTIVE DEVICES

Definition

Protective devices (safety equipment) in use or worn at the time of the injury.

Field Values

LA COUNTY	NTDB		
Protective Devices (PH_12)	**Protective Devices (I_13)**	**Child Specific Restraint (I_14)**	**Airbag Deployment (I_15)**
PROTECTIVE DEVICES			
NO None	None	N/A	N/A
HE Helmet	Helmet	N/A	N/A
PC Protective Clothing	Protective Clothing	N/A	N/A
PG Protective Gear (non-clothing)	Protective Non-Clothing Gear	N/A	N/A
EP Eye Protection	Eye protection	N/A	N/A
PF Personal Flotation Device	Personal Flotation Device	N/A	N/A
SB Seatbelt - Shoulder Belt	Shoulder Belt	N/A	N/A
LB Seatbelt - Lap Belt	Lap Belt	N/A	N/A
OT Other	Other	N/A	N/A
AIRBAG			
AN Airbag Not Deployed	Airbag Present	N/A	Airbag Not Deployed
AF Airbag - Front	Airbag Present	N/A	Airbag Deployed Front
AS Airbag - Side	Airbag Present	N/A	Airbag Deployed Side
AO Airbag - Other	Airbag Present	N/A	Airbag Deployed Other
CHILD RESTRAINTS			
IC Infant Car Seat (up to 1yr/20lbs)	Child Restraint	Infant Car Seat	N/A
CC Child Car Seat (>1yr/20-40lbs)	Child Restraint	Child Car seat	N/A
CB Child Booster (>40lbs/<4'9")	Child Restraint	Child Booster Seat	N/A

Additional Information

- A value of *"None"* **MUST** be entered if no protective devices are in use at the time of injury.
- *If "Child Restraint" is present, complete variable "Child Specific Restraint"*.
- *If "Airbag" is present, complete variable "Airbag Deployment"*.
- The null value *"Not Applicable"* is used if no "*Airbag*" is reported under Protective Devices.
- Presence or use of protective devices may be reported or observed.
- Indicate all that apply.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form (preferred)
2. ED Records (if above determined to be inaccurate or incomplete)

Uses

- Used to better define injury cause and characterize injury patterns.

Other Associated Elements

- INJURY DESCRIPTION
- MECHANISM OF INJURY
- BLUNT vs PENETRATING

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

1st FIELD VS: BP (Systolic)

Definition

First recorded systolic blood pressure measured at the scene of injury.

Field Values

- Relevant value for data element

Additional Information

- Utilize "*Not Documented*" for references to capillary refill, or if reported to be "unable to obtain".
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

Other Associated Elements

- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: BP (Diastolic)

Definition

First recorded diastolic blood pressure measured at the scene of injury.

Field Values

- Relevant value for data element

Additional Information

- The null value "*Not Documented*" is used if the diastolic pressure is not measured (i.e., only palpated SYSTOLIC pressure measured).
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: HR

Definition

First recorded pulse rate measured at the scene of injury ***(palpated or auscultated ONLY – no monitor readings)***, expressed as a number per minute.

Field Values

- Relevant value for data element

Additional Information

- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st FIELD VS: RR

Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

Field Values

- Relevant value for data element

Additional Information

- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st FIELD VS: O_2 SAT %

Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Field Values

- Relevant value for data element

Additional Information

- Value should be based upon assessment before the administration of oxygen.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st FIELD GCS: EYE

Definition

First recorded Glasgow Coma Eye Score measured at the scene of injury.

Field Values

- 4 Opens eyes spontaneously
- 3 Opens eyes in response to verbal stimulation
- 2 Opens eyes in response to painful stimulation
- 1 No eye opening

Additional Information

- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Overall GCS - EMS Score.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 4 **Accepts Null Value:** Yes

1st FIELD GCS: VERBAL

Definition

First recorded Glasgow Coma Verbal Score measured at the scene of injury.

Field Values

	ADULT	INFANT
5	Oriented X 3	Smiling or cooing appropriately
4	Confused	Crying but consolable
3	Inappropriate words	Crying or screaming is persistent and inappropriate for the incident
2	Incomprehensible sounds	Grunts, agitated, or restless
1	No verbal response	No verbal response

Additional Information

- If the patient is intubated then the GCS Verbal score is equal to 1.
- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Overall GCS - EMS Score.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: MOTOR
- 1st Field GCS: TOTAL

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

1st FIELD GCS: MOTOR

Definition

First recorded Glasgow Coma Motor Score measured at the scene of injury.

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Additional Information

- The null value *"Not Applicable"* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Overall GCS - EMS Score.

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: TOTAL

Data Format: [number] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

1st FIELD GCS: TOTAL

Definition

First recorded Glasgow Coma Score Total measured at the scene of injury.

Field Values

- Relevant value for data element

Additional Information

- Entering values for each of the GCS component fields will result in an auto-calculated 1st FIELD GCS: TOTAL.
- Value may be hand-entered if GCS component fields are not documented, but a GCS total is recorded.
- If a patient does not have a numeric GSC recorded, but documentation related to their level of consciousness exists such as, “awake, alert, and oriented”, this may be interpreted as a GCS of 15, if no other contraindicating information exists.
- The null value *“Not Applicable”* is auto-populated for non-EMS patients.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

Other Associated Elements

- 1st Field VS: BP (Systolic)
- 1st Field VS: BP (Diastolic)
- 1st Field VS: HR
- 1st Field VS: RR
- 1st Field VS: O_2 SAT %
- 1st Field GCS: EYE
- 1st Field GCS: VERBAL
- 1st Field GCS: MOTOR

Data Format: [number, 2] single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

FIELD INTUBATION?

Definition

One-letter code indicating whether or not the patient was intubated in the prehospital setting.

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. EMS Report Form

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st Field VS: RR
- 1st Field VS: O_2 SAT %

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PREHOSPITAL CARDIAC ARREST?

Definition

Indicates whether the patient experienced cardiac arrest prior to ED / Hospital arrival.

Field Values

- Y (Yes)
- N (No)

Additional Information

- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside of the hospital, prior to admission at the center in which the registry is maintained. Prehospital cardiac arrest could occur at a transferring facility.
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.
- Since PREHOSPITAL CARDIA ARREST does not occur in the majority of patients, this field will auto-populate with a value of 'No'. In those cases where the patient did experience a cardiac arrest prior to ED / Hospital arrival, the 'No' value will need to be changed.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Nurses Notes
3. History & Physical
4. Transfer Records

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- FIELD INTUBATION?

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PRIMARY EXTERNAL CAUSE CODE

Definition

External cause code used to describe the mechanism (or external factor) that caused the injury event.

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- The primary external causes of injury code should describe the main reason a patient is admitted to the hospital.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by mechanism causing the injury.
- EXTERNAL CAUSE CODES are used to auto-generated two calculated fields: Trauma Type (Blunt vs Penetrating) and Intentionality.

Other Associated Elements

- ADDITIONAL EXTERNAL CAUSE CODE
- LOCATION E-CODE

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ADDITIONAL EXTERNAL CAUSE CODE

Definition

Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the event.

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- The null value *"Not Applicable"* is used if no additional external cause codes are used.
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by mechanism causing the injury.
- EXTERNAL CAUSE CODES are used to auto-generated two calculated fields: Trauma Type (Blunt vs Penetrating) and Intentionality.

Other Associated Elements

- PRIMARY EXTERNAL CAUSE CODE
- PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PLACE OF OCCURRENCE EXTERNAL CAUSE CODE

Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).

Field Values

- Relevant ICD-10-CM code value for injury event

Additional Information

- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes.
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows injuries to be characterized by the place/site/location of the injury.

Other Associated Elements

- PRIMARY EXTERNAL CAUSE CODE
- ADDITIONAL EXTERNAL CAUSE CODE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 0 **Max Value:** 9 **Accepts Null Value:** Yes

INJURY LOCATION ZIP CODE

Definition

The ZIP code of the incident location.

Field Values

- Relevant value for data element

Additional Information

- Use 5 digit code (XXXXX).
- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION CITY, INJURY LOCATION COUNTY, and INJURY LOCATION STATE.
- If *"Not Documented"*, or *"Not Known"*, must complete variables of INJURY LOCATION CITY; INJURY LOCATION COUNTY and INJURY LOCATION STATE.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon the geographic location of the injury.
- Used to calculate FIPS code.

Other Associated Elements

- INJURY LOCATION CITY
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 90001 (CA) **Max Value:** 96162 (CA) **Accepts Null Value:** Yes

INJURY LOCATION CITY

Definition

The city (or township, or village) where the injury occurred.

Field Values

Picklist contains all cities within the following counties:

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information

- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION CITY.
- Select city from picklist, or enter non-picklisted city directly.
- Only completed when INJURY LOCATION ZIP CODE is *"Not Documented"* or *"Not Known"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury.
- Used to calculate FIPS code.

Other Associated Elements

- INJURY LOCATION ZIP CODE
- INJURY LOCATION COUNTY
- INJURY LOCATION STATE

Data Format: [character, 30] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INJURY LOCATION COUNTY

Definition

The county (or parish) where the injury occurred.

Field Values

- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- Ventura

Additional Information

- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate INJURY LOCATION COUNTY.
- Select county from picklist, or enter non-picklisted county directly.
- Only completed when INJURY LOCATION ZIP CODE is *"Not Documented"* or *"Not Known"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury.
- Used to calculate FIPS code.

Other Associated Elements

- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION STATE

Data Format: [character, 30] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INJURY LOCATION STATE

Definition

The two-letter code for the state (territory, province, or District of Columbia) where the injury occurred.

Field Values

- Picklist contains codes for all of the United States and its territories

Additional Information

- Data entry of a valid INJURY LOCATION ZIP CODE will auto-populate the INJURY LOCATION STATE.
- Only completed when INJURY LOCATION ZIP CODE is *"Not Documented"* or *"Not Known"*.
- The null value *"Not Applicable"* is auto-populated if INJURY LOCATION ZIP CODE is entered.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Report Form
2. ED Records

Uses

- Allows data to be sorted based upon the geographic location of the patient's injury.
- Used to calculate FIPS code.

Other Associated Elements

- INJURY LOCATION ZIP CODE
- INJURY LOCATION CITY
- INJURY LOCATION COUNTY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

WORK RELATED?

Definition

Indication of whether the injury occurred during paid employment.

Field Values

- Y (Yes)
- N (No)

Additional Information

- If WORK RELATED, must be completed: OCCUPATION and INDUSTRY.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. EMS Report Form

Uses

- Allows characterization of injuries associated with job environments.

Other Associated Elements

- INDUSTRY
- OCCUPATION

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

OCCUPATION

Definition

The occupation of the patient.

Field Values

LA COUNTY	
ARCH/ENG	Architecture and Engineering Occupations
ARTS	Arts, Design, Entertainment, Sports, and Media
BUILD/MAINT	Building and Grounds Cleaning and Maintenance
BUS/FIN	Business and Financial Operations Occupations
COMM/SOC	Community and Social Services Occupations
COMP/MATH	Computer and Mathematical Occupations
CONSTRUCTION	Construction and Extraction Occupations
ED/TRAINING	Education, Training, and Library Occupations
FARMING	Farming, Fishing, and Forestry Occupations
FOOD	Food Preparation and Serving Related
HEALTH PRACT	Healthcare Practitioners, and Technical Occupations
HEALTH SUPPORT	Healthcare Support Occupations
INST/MAINT	Installation, Maintenance, and Repair Occupations
LEGAL	Legal Occupations
MANAGEMENT	Management Occupations
MILITARY	Military Specific Occupations
OFFICE	Office and Administrative Support Occupations
PERSONAL	Personal Care and Service Occupations
PRODUCTION	Production Occupations
PROTECTIVE	Protective Service Occupations
SALES	Sales and Related Occupations
SCIENCE	Life, Physical and Social Science Occupations
TRANSPORTATION	Transportation and Material Moving Occupations
UNEMPLOYED	Unemployed

Additional Information

- Only completed if injury is WORK RELATED – must also complete INDUSTRY.
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC).
- Field value cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. History & Physical
3. ED Nurses Notes
4. Triage Form / Trauma Flow Sheet
5. EMS Report Form

Uses

- Can be used to better describe injuries associated with work environments.

Other Associated Elements

- WORK RELATED?
- INDUSTRY

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INDUSTRY

Definition

The occupational industry associated with the patient's work environment.

Field Values

LA COUNTY	
AGRICULTURAL	Agricultural, Forestry, Fishing
CONSTRUCTION	Construction
ED/HEALTH	Education and Health
INFORMATION	Information Services
FIN/INS/REAL	Finance, Insurance, and Real Estate
GOVERNMENT	Government
LEISURE	Leisure and Hospitality
MANUFACTURING	Manufacturing
NATURAL	Natural Resources and Mining
PROFESSIONAL	Professional and Business Services
RETAIL	Retail Trade
TRANS/UTIL	Transport and Public Utilities
WHOLESALE	Wholesale Trade
OTHER	Other Services

Additional Information

- Only completed if injury is WORK RELATED – must also complete OCCUPATION.
- Field value cannot be left blank.

Data Source Hierarchy

1. Facesheet
2. History & Physical
3. ED Nurses Notes
4. Triage Form / Trauma Flow Sheet
5. EMS Report Form

Uses

- Can be used to better describe injuries associated with work environments.

Other Associated Elements

- WORK RELATED?
- OCCUPATION

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

EMERGENCY DEPARTMENT

ED NOTIFIED?

Definition

Indicates whether or not the Emergency Department received notification prior to the patient's arrival.

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MD SERVICE
- MD CODE
- STAT?
- REQ TIME
- ARR TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MET CRITERIA?

Definition

Indicates whether or not the patient met **TRAUMA CRITERIA** per LA County Reference No. 506.

Field Values

- Y (Yes)
- N (No)
- U (Unknown)

Additional Information

- **Do not include patients that meet TRAUMA GUIDELINES / SPECIAL CONSIDERATION.**

Data Source Hierarchy

1. EMS Report Form
2. ED Records
3. Base hospital records

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- CRITERIA MET
- GUIDELINES / SPECIAL CONSIDERATION MET
- TPS RATIONALE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CRITERIA MET

Definition

Trauma Criteria, per LA County Reference No. 506, met by the patient.

Field Values

LA COUNTY		NTDB Physiologic & Anatomic / Mechanism of Injury	
14	Blunt Head with GCS≤14	1	Glasgow Coma Score ≤13
15	Adult fall from heights >15 feet, or Peds from heights >10 feet, or >3 times child's height	1 2	Adult fall from heights >15 feet, or Peds from heights >10 feet, or >3 times child's height
20	Unenclosed vehicle crash impact >20 mph	8	Motorcycle crash >20 mph
70	Blood Pressure <70mmHg Systolic Infant	2	Blood Pressure <90mmHg Systolic
90	Blood Pressure <90mmHg Systolic Adult	2	Blood Pressure <90mmHg Systolic
RR	Respiratory Rate <10/>29, <20 if <1yr.	3	Respiratory Rate <10/>29, <20 if <1yr.
FC	Flail Chest	5	Chest wall instability or deformity
SX	Suspected Pelvic Fracture	9	Pelvic Fracture
SC	Spinal Cord Injury with Sensory Deficit	11	Paralysis
EJ	Ejected	4	Crash ejection (partial or complete)
PS	Passenger Space Intrusion of 12 inches into an occupied passenger space	3	Intrusion >12 in. occupant site; 18 in. any site
RT	Pedestrian/Bicyclist Thrown / Runover / Impact >20 mph	7	Pedestrian/Bicyclist Thrown / Runover / Impact >20 mph
BD	Blunt Abdomen with Diffuse Abd. Tenderness	N/A	
BI	Blunt Amputation above the Wrist or Ankle	8	Amputation proximal to the wrist or ankle
BR	Blunt Fractures of Two or More Long Bones	6	Two or more proximal long-bone fractures
BV	Blunt Extremity with Neuro / Vascular / Mangled	7	Crushed, degloved, mangled, or pulseless extremity
PA	Penetrating Abdomen	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PC	Penetrating Chest	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PF	Penetrating Face/Mouth	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PG	Penetrating Genitals	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PH	Penetrating Head	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PI	Penetrating Amputation above the Wrist or Ankle	8	Amputation proximal to the wrist or ankle
PK	Penetrating Buttocks	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PN	Penetrating Neck	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PT	Penetrating Full Arrest	N/A	
PV	Penetrating Extremity with Neuro / Vascular / Mangled	7	Crushed, degloved, mangled, or pulseless extremity
PX	Penetrating Extremity above the Elbow or Knee	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
PY	Penetrating Back	4	Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee

Additional Information

- If CRITERIA MET field value is "No", values from the "Criteria" sub-picklist may NOT be selected.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital Records
3. ED Records

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MET CRITERIA?
- GUIDELINES / SPECIAL CONSIDERATION MET
- TPS RATIONALE

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

GUIDELINES / SPECIAL CONSIDERATION MET

Definition

Trauma Guidelines / Special Considerations, per LA County Reference No. 506, met by the patient.

Field Values

GUIDELINES		NTDB Physiologic & Anatomic Mechanism of Injury & Other Risk Injury	
18	Passenger Space Intrusion of 18 inches into an unoccupied passenger space	3	Intrusion >12 inches occupant site
AN	Anticoagulant Medication (other than aspirin only) or with Bleeding Disorder	10	Patients on anticoagulants and bleeding disorders
EX	Extrication Required	N/A	
PB	Pedestrians/Bicyclists Impact ≤ 20 mph	N/A	
SF	Survivor of Fatal Crash (same vehicle), with Complaint of Injury	5	Crash death in same passenger compartment
TD	Telemetry Data	6	Telemetry data consistent w/ high risk injury
SPECIAL CONSIDERATIONS		**NTDB Physiologic & Anatomic Mechanism of Injury**	
55	Age greater than 55 years	N/A	
BP	Systolic B/P less than 110mmHg for patient greater than 65 years of age	9	Adults greater than 65 years of age with Systolic B/P less than 110mmHg
IU	Pregnancy greater than 20 weeks	11	Pregnancy greater than 20 weeks
PJ	Prehospital judgment that transport to Trauma Center is in the pt's best interest	12	EMS provider judgment

Additional Information

- Special consideration is not applicable for non-EMS patients.
- Special consideration is not to be used if an existing criteria or guideline exists.

Data Source Hierarchy

1. EMS Report Form
2. Base Hospital Records
3. ED Records

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MET CRITERIA?
- CRITERIA MET
- TPS RATIONALE

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ED ARRIVAL TIME

Definition

The time the patient arrived to the ED / Hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Used to calculate Total EMS Time and Total Length of Hospital Stay.
- This field auto-populates from the data entered for ARRIVAL TIME from the GENERAL INFORMATION section.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. EMS Report Form

Uses

- Allows data to be sorted based upon arrival date / time.
- Allows data to be sorted based upon total length of hospital stay.

Other Associated Elements

- ARRIVAL DATE
- DISPATCH DATE / TIME
- 1st ON SCENE
- TRANSPORT ARRIVAL DATE / TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ACTIVATION?

Definition

Indicates whether or not the treating facility's Trauma Team was activated.

Field Values

- Y (Yes)
- N (No)

Additional Information

- The responding team must include the Trauma Surgeon or a post-graduate year four (PGY4) surgical resident (minimum) – regardless of the level of trauma activation.
- **Requests for Trauma Consults are NOT considered Activations.**

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows data to be sorted based upon TPS RATIONALE and level of facility response.

Other Associated Elements

- TPS RATIONALE
- TIME (OF ACTIVATION)
- LEVEL (OF ACTIVATION)

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TIME *(OF ACTIVATION)*

Definition

If applicable, the time that the treating facility's Trauma Team was activated.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows monitoring of Trauma Team response times.

Other Associated Elements

- TPS RATIONALE
- ACTIVATION?
- LEVEL (OF ACTIVATION)

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

LEVEL *(OF ACTIVATION)*

Definition

If applicable, the level of the Trauma Team's activation.

Field Values

- Customized list

Additional Information

- Enter LEVEL (*OF ACTIVATION)* or code directly, or create facility-specific picklist.
- **Requests for Trauma Consults are NOT considered Activations.**

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Allows monitoring of Trauma Team response times and sorting of data based upon level of response.

Other Associated Elements

- TPS RATIONALE
- ACTIVATION?
- TIME (OF ACTIVATION)

Data Format: [character, 3] single entry **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ED DISPOSTION ORDER DATE

Definition

The **date the order was written** for the patient to be dispositioned from the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Data Source Hierarchy

1. Physician's Progress Notes
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of ED stay.
- Used to calculate Total ED Time.

Other Associated Elements

- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ED DISPOSTION ORDER TIME

Definition

The **time the order was written** for the patient to be dispositioned from the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Hospital Record

Uses

- Allows data to be sorted based upon ED length of stay.
- Used to calculate Total ED Time.

Other Associated Elements

- ED DISPOSITION ORDER DATE
- ED EXIT DATE
- ED EXIT TIME
- NEXT PHASE AFTER ED

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ED EXIT DATE

Definition

The date the patient was discharged from the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Data Source Hierarchy

1. Physician's Progress Notes
2. Billing Sheet / Medical Records Coding Summary Sheet
3. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon total length of ED stay.
- Used to calculate Total ED Time.

Other Associated Elements

- ED DISPOSITION ORDER DATE
- ED DISPOSITION ORDER TIME
- ED EXIT TIME
- NEXT PHASE AFTER ED

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ED EXIT TIME

Definition

The time the patient was discharged from the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is used if the patient is directly admitted to the hospital.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Hospital Record

Uses

- Allows data to be sorted based upon ED length of stay.
- Used to calculate Total ED Time.

Other Associated Elements

- ED DISPOSITION ORDER DATE
- ED DISPOSITION ORDER TIME
- ED EXIT DATE
- NEXT PHASE AFTER ED

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

HEIGHT

Definition

Patient's height, or the best approximation, upon ED / hospital arrival.

Field Values

- Relevant value for data element

Additional Information

- May be self-reported or provided by family.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Other Associated Elements

- INCHES vs CENTIMETERS *(Height Units)*

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 244 **Accepts Null Value:** No

INCHES vs CENTIMETERS *(Height Units)*

Definition

Patient's height, or the best approximation, upon ED / hospital arrival.

Field Values

- I (Inches)
- C (Centimeters)

Additional Information

- May be self-reported or provided by family.

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Other Associated Elements

- HEIGHT

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 244 **Accepts Null Value:** No

WEIGHT

Definition

Patient's weight, or the best approximation, upon ED / hospital arrival.

Field Values

- Relevant value for data element

Additional Information

- May be self-reported or provided by family.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Other Associated Elements

- POUNDS vs KILOGRAMS *(Weight Units)*

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 907 **Accepts Null Value:** No

POUNDS vs KILOGRAMS *(Weight Units)*

Definition

Patient's weight, or the best approximation, upon ED / hospital arrival.

Field Values

- L (Pounds)
- K (Kilograms)

Additional Information

- May be self-reported or provided by family.

Data Source Hierarchy

1. ED Nurses Notes
2. EMS Report Form
3. Triage Form / Trauma Flow Sheet
4. Billing Sheet / Medical Records Coding Summary Sheet
5. ED Admission Form

Uses

- Allows data to be sorted based upon age

Other Associated Elements

- WEIGHT

Data Format: [character, 3] single entry **Picklist:** No
Min Value: N/A **Max Value:** 907 **Accepts Null Value:** No

1st ED VS: TIME

Definition

Time of the first recorded vital signs in the ED / hospital within 30 minutes of arrival.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- All timed values are tied to a date and time; therefore, the 1st Set of ED Vitals at the ED Receiving facility (Trauma Center) must be used, NOT the 1st Set of documented ED vitals from the ED Sending facility. Although this will result in variance in the Revised Trauma Score, vital signs that are timed prior to ED arrival at the Trauma Center will result in data validation issues.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ED VS: BP – SYSTOLIC

Definition

Numeric value of the patients first recorded systolic blood pressure in the ED / hospital within 30 minutes of arrival.

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / diastolic value

Additional Information

- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st ED VS: BP – DIASTOLIC

Definition

Numeric value of the patients first recorded diastolic blood pressure in the ED / hospital within 30 minutes of arrival.

Field Values

- Up to three-digit numeric value
- Documented as numeric systolic value / diastolic value

Additional Information

- The null value "*Not Documented*" is used if the diastolic pressure is not measured (i.e., only palpated SYSTOLIC pressure measured).

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

1st ED VS: HR

Definition

First recorded pulse *(palpated or auscultated ONLY – no monitor readings)* in the ED / hospital within 30 minutes of arrival, expressed as a number per minute.

Field Values

- Relevant value for data element

Additional Information

- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 400 **Accepts Null Value:** Yes

1st ED VS: RR

Definition

First recorded respiratory rate in the ED / hospital within 30 minutes of arrival, expressed as a number per minute.

Field Values

- Relevant value for data element

Additional Information

- Enter actual rate only – indicate whether or not respirations were assisted in the next field: "ASST?"
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - ED (adult & pediatric).

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st ED VS: ASST? *(Resp)*

Definition

Determination of respiratory assistance associated with the initial ED / hospital respiratory rate within 30 minutes of arrival.

Field Values

- Y (Yes)
- N (No)

Additional Information

- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** No

1st ED VS: O_2 SAT

Definition

First recorded oxygen saturation in the ED / hospital within 30 minutes of arrival, expressed as a percentage.

Field Values

- Relevant value for data element

Additional Information

- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 3] single entry **Picklist:** No
Min Value: 0 **Max Value:** 100 **Accepts Null Value:** Yes

1st ED VS: ON O_2? *(O_2 Sat)*

Definition

Determination of the presence of supplemental oxygen during assessment of initial ED / hospital oxygen saturation level within 30 minutes of arrival.

Field Values

- Y (Yes)
- N (No)
- U (Unknown)

Additional Information

- Only complete if a value is reported for 1st ED VS: O_2 SAT, otherwise value is *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

1st ED VS: TEMP

Definition

First recorded temperature in the ED / hospital within 30 minutes of arrival.

Field Values

- Relevant value for data element

Additional Information

- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 5] single entry **Picklist:** No
Min Value: 25 **Max Value:** 110 **Accepts Null Value:** Yes

FAHRENHEIT vs CELSIUS *(1st Temp Units)*

Definition

Units of measurement for first recorded temperature in the ED / hospital within 30 minutes of arrival.

Field Values

- F (Fahrenheit)
- C (Celsius)

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TIME *(1st Temp)*

Definition

First recorded temperature in the ED / hospital within 30 minutes of arrival.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1st ED VS: GCS – EYE

Definition

First recorded Glasgow Coma Eye Score in the ED / hospital within 30 minutes of arrival.

Field Values

- 4 Opens eyes spontaneously
- 3 Opens eyes to verbal stimulation
- 2 Opens eyes to painful stimulation
- 1 No eye opening

Additional Information

- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Total GCS.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 4 **Accepts Null Value:** Yes

1st ED VS: GCS – VERBAL

Definition

First recorded Glasgow Coma Verbal Score in the ED / hospital within 30 minutes of arrival.

Field Values

	ADULT	INFANT
5	Oriented X 3	Smiling or cooing appropriately
4	Confused	Crying but consolable
3	Inappropriate words	Crying or screaming is persistent and inappropriate for the incident
2	Incomprehensible sounds	Grunts, agitated, or restless
1	No verbal response	No verbal response

Additional Information

- If the patient is intubated then the GCS Verbal score is equal to 1.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Total GCS.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

1st ED VS: GCS – MOTOR

Definition

First recorded Glasgow Coma Motor Score in the ED / hospital within 30 minutes of arrival.

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Additional Information

- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Total GCS.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL / QUALIFIERS

Data Format: [number, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

1st ED VS: GCS – TOTAL

Definition

First recorded Total Glasgow Coma Score in the ED / hospital within 30 minutes of arrival.

Field Values

- Relevant value for data element

Additional Information

- Is auto-calculated if components are entered, or total can be hand-entered if components not available.
- If a patient does not have a numeric GCS recorded, but documentation related to their level of consciousness exists, i.e., AAOx3, awake alert and oriented, or patient with normal mental status, interpret this as GCS of 15, IF there is no other contraindicating documentation.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.
- Used to calculate Revised Trauma Score - EMS (adult & pediatric).

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – QUALIFIERS

Data Format: [number, 2] single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

1st ED VS: GCS *(Qualifiers)*

Definition

Documentation of factors potentially affecting the first assessment of GCS upon arrival in the ED / hospital within 30 minutes of arrival.

Field Values

- S Sedated
- E Eye Obstruction
- I Intubated

Additional Information

- Identified medical treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.).
- If patient was not chemically sedated, intubated, and did not have eye obstruction then code as "*Not Applicable*".
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ED VS: BP – TIME
- 1st ED VS: BP – SYSTOLIC
- 1st ED VS: BP – DIASTOLIC
- 1st ED VS: HR
- 1st ED VS: RR / ASST?
- 1st ED VS: O_2 SAT / ON O_2?
- 1st ED VS: TEMP / UNITS / TIME
- 1st ED VS: GCS – EYE
- 1st ED VS: GCS – MOTOR
- 1st ED VS: GCS – VERBAL
- 1st ED VS: GCS – TOTAL

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TPS RATIONALE

Definition

The patient's primary rationale for TPS completion and inclusion in the TEMIS database.

Field Values

LA COUNTY	
PH	Prehospital care personnel made destination decision to transport to a Trauma Center based on criteria, guidelines, or judgment – must be documented on EMS report form
CG	Non-EMS patient met trauma criteria or guidelines (excluding Prehospital Judgment)
AD	Admitted to **your** hospital for care of an injury **after Trauma service evaluation in the ED**
DI	Died of an injury-related problem
TS	Transferred to or from your facility for care of an injury
NO	DHS = No – use for patients not meeting Exhibit C inclusion criteria that your facility wishes to capture in your hospital database (e.g., hangings, or patients being followed for special studies)

Additional Information

- Always use the rationale that occurs *first* in the patient's course of treatment.
- Prehospital judgment is not applicable for non-EMS patients.

Data Source Hierarchy

1. ED Records
2. EMS Report Form
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon TPS Rationale.
- Used in quality management for the evaluation of care.

Other Associated Elements

- DHS? Y N
- MET CRITERIA?
- CRITERIA MET
- GUIDELINES / SPECIAL CONSIDERATION MET

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ADMITTING MD

Definition

The physician primarily responsible for admitting patient to the hospital, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text physician's name or code at discretion of facility.

Data Source Hierarchy

1. ED Admission Form
2. Billing Sheet / Medical Records Coding Summary Sheet
3. ED Records

Uses

- Allows data to be sorted based upon Admitting MD.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ADMITTING SERVICE

Data Format: [character, 15] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ADMITTING SERVICE

Definition

The three-letter code for physician service primarily responsible for admitting patient to the hospital, if applicable.

Field Values

- Relevant value for data element

Data Source Hierarchy

1. ED Records
2. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon Admitting Service.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ADMITTING MD

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD SERVICE

Definition

Services activated to evaluate patient upon arrival, or services consulted during the ED phase of care.

Field Values

LA COUNTY					
ANE	ANESTHESIOLOGY	NEP	NEPHROLOGY	POS	PEDIATRIC ORTHOPEDIC
CAR	CARDIOLOGY	NEU	NEUROLOGY	POT	PED. OTOLARYNGOLOGY
CTS	CARDIOTHORACIC SURGEON	NER	NEURORADIOLOGY	PEP	PEDIATRIC PATHOLOGY
CCI	CRITICAL CARE INTENSIVIST	NES	NEUROSURGEON	PPY	PEDIATRIC PSYCHIATRIST
DEN	DENTAL	OBS	OBSTERICS	PPS	PED. PULM. SPECIALIST
DER	DERMATOLOGY	OPS	OPTHAL. SURGEON	PER	PEDIATRIC RADIOLOGY
EDP	ED PHYS/ATTENDING	ORS	ORAL SURGEON	PES	PEDIATRIC SURGEON
EDR	ED RESIDENT	ORT	ORTHOPEDICS	PUR	PEDIATRIC UROLOGY
END	ENDOCRINOLOGY	ONL	OTHER NOT LISTED	PED	PEDIATRICS
FNM	FAMILY MEDICINE	OTO	OTOLARYNGOLOGY	PHY	PHYSIATRY
GAS	GASTROENTEROLOGY	PAL	PALLIATIVE CARE	PLS	PLASTIC SURGEON
GES	GENERAL SURGEON	PAT	PATHOLOGY	POD	PODIATRY
GER	GERIATRICS	PEA	PEDIATRIC ALLERGY	PTN	PRIMARY TRAUMA NURSE
GYN	GYNECOLOGY	PEC	PEDIATRIC CARDIOLOGY	PSC	PSYCHOLOGY
HAS	HAND SURGEON	PCA	PEDIATRIC CHILD ADVOCACY	PSY	PSYCHIATRY
HEM	HEMATOLOGY	PCS	PED. CARDIOTHOR. SURGEON	PUL	PULMONARY SPECIALIST
HMO	HMO CONSULTANT	PEN	PEDIATRIC ENDOCRINOLOGY	RAD	RADIOLOGY
HNS	HEAD & NECK SURGEON	PEG	PED. GASTROENTEROLOGY	RHE	RHEUMATOLOGY
HBO	HYPERBARIC MEDICINE	PEH	PEDIATRIC HEMATOLOGY	SPI	SPINAL
INF	INFECTIOUS MEDICINE	PEI	PEDIATRIC INTENSIVIST	THS	THORACIC SURGEON
INR	INTERVENT. RADIOLOGY	PMS	PAIN MANAGE SPECIALIST	TRR	TRAUMA RESIDENT
INT	INTERNAL MEDICINE	PNP	PEDIATRIC NEPHROLOGY	TRS	TRAUMA SURG/ATTEND
MAS	MAXILLOFACIAL SURGEON	PNE	PEDIATRIC NEUROLOGY	URO	UROLOGY
NCC	NEURO CRITICAL CARE	PNR	PEDIATRIC NEURORADIOLOGY	VAS	VASCULAR SURGEON
NEO	NEONATOLOGY	PNS	PEDIATRIC NEUROSURGEON		

Additional Information

- Trauma Team composition will vary by facility policy

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon physician service.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MD CODE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [character, 3] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

Definition

Name or code of Trauma Team physician activated to evaluate patient upon arrival, or services consulted during the ED phase of care.

Field Values

- Relevant value for data element

Additional Information

- Enter physician name or code directly, or create facility-specific picklist.

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon responding physician.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MD SERVICE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [character, 5] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

REQUEST TIME *(MD)*

Definition

Time that Trauma Team physician was contacted to request evaluation of injured patient.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon responding physician.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MD SERVICE
- REQ TIME
- STAT?
- ARR TIME

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

STAT? *(MD)*

Definition

Indicates whether or not the Trauma Team physician was asked to respond immediately (responding without delay when notified) to evaluate the injured patient.

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MD SERVICE
- MD CODE
- REQ TIME
- ARR TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ARRIVAL TIME *(MD)*

Definition

Time that Trauma Team physician **arrived at the bedside to evaluate the injured patient** in the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- A “phone response” is NOT to be utilized as an *Arrival Time*. Physical evaluation of the patient is not possible via the phone.

Data Source Hierarchy

1. ED Records
2. History and Physical
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- MD SERVICE
- MD CODE
- REQ TIME
- STAT?

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

1ST ANTIBIOTIC ADMIN. DATE

Definition

Date of 1st antibiotic administration for patients that meet the collection criteria.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH BLUNT OPEN TIBIAL FRACTURE.**

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon antibiotic administration.

Other Associated Elements

- 1st ANTIBIOTIC ADMIN. TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

1ST ANTIBIOTIC ADMIN. TIME

Definition

Time of 1st antibiotic administration for patients that meet the collection criteria.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH BLUNT OPEN TIBIAL FRACTURE.**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.

Data Source Hierarchy

1. ED Records

Uses

- Used in quality management for the evaluation of care.

Other Associated Elements

- 1st ANTIBIOTIC ADMIN. DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

IV FLUIDS IN ED

Definition

Total amount of all crystalloids and colloids, excluding blood products, received by the patient in the ED.

Field Values

- Relevant value for data element

Additional Information

- Collected as milliliters – not liters or units.
- If IV fluids are documented, but the specific amount is not recorded, "*Not Documented*" is entered.

Data Source Hierarchy

1. ED Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

ARRIVED WITH SIGNS OF LIFE?

Definition

Indication of whether the patient arrived at the ED / Hospital with signs of life.

Field Values

- Y (Yes)
- N (No)

Additional Information

- A patient with no signs of life is defined as having none of the following:
  - Organized EKG activity
  - Pupillary responses
  - Spontaneous respiratory effort
- This usually implies that the patient arrived with CPR in progress.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon ED phase of care.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- DEATH IN ED
- NEXT PHASE AFTER ED
- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DEATH IN ED

Definition

Resuscitation details of patients who expire in the ED.

Field Values

LA COUNTY	
D DOA	Death declared **on arrival** no invasive procedures attempt
F Failed resuscitation (<15min)	Death in ED **within 15 minutes** of failed resuscitation attempt
O Died in ED	Death in ED **of other than failed resuscitation attempt**

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon post-ED phase of care.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ARRIVED WITH SIGNS OF LIFE?
- NEXT PHASE AFTER ED
- EXIT ED DATE/TIME
- TRANSFERRED / D/C'D TO
- PHASE PRIOR D/C

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

NEXT PHASE AFTER ED

Definition

Phase of care occurring directly after the ED phase (ED disposition).

Field Values

LA COUNTY	NTDB	
23HR OBS	2	Observation unit (provides < 24 hour stays)
ICU	8	Intensive Care Unit (ICU)
INTERVENTIONAL RADIOLOGY (IR)	8	Intensive Care Unit (ICU)
OR	7	Operating Room
PICU	8	Intensive Care Unit (ICU)
PEDSWARD	1	Floor bed (general admission, non-specialty bed)
SPECIAL PROCEDURES (anything other than IR)	8	Intensive Care Unit (ICU)
STEPDOWN	3	Telemetry/step-down unit (less acuity than ICU)
WARD	1	Floor bed (general admission, non-specialty bed)
POSTHOSP *(Uses LA County "TRANSFERRED / D/C TO:"):*		
HOME W/O	9	Home without services
HOME WITH	4	Home with services
MORGUE	5	Died
JAIL SCJ USC (Jail Ward at LAC+USC) REHAB SNF SUBACUTE CARE	6	Other (jail, institutional care, mental health, etc)
HOSPICE	4 6	Home with services, OR Other (jail, institutional care, mental health, etc)
AMA/ELOPED/LWBS	10	Left against medical advice
ACUTE CARE BURN CENTER TRAUMA CENTER	11	Transferred to another hospital
Long Term Care Hospital (LTCH)	12	Discharged Transferred to Long Term Care Hospital
Psych	13	Discharged Transferred to a psych facility or unit
OTHER	F5	

Additional Information

- Next phase begins when patient is no longer being cared for by the ED or ED personnel with the exception of Interventional Radiology and/or Special procedures.

Data Source Hierarchy

1. ED Records

Uses

- Allows data to be sorted based upon post-ED phase of care.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- EXIT ED DATE/TIME
- DEATH IN ED (if applicable)
- TRANSFERRED / D/C'D TO

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY / LABORATORY

RADIOLOGY: Body Part / Study

Definition

Body region and radiological study performed during hospital stay that were essential to the diagnosis of patient's specific injuries, if applicable.

Field Values

BODY PART	X-Ray	CT	CT w/contrast	BODY PART	X-Ray	CT	CT w/contrast
HEAD				**UPPER EXTREMITIES**	BW0JZZZ		
Head / Skull	BN00ZZZ	BW28ZZZ	BW281ZZ	Right Upper Extremity	BP0EZZZ	BP2TZZZ	BP2T1ZZ
Brain		B020ZZZ	B0201ZZ	Right hand	BP0NZZZ	BP2NZZZ	BP2N1ZZ
Orbits	BN03ZZZ	BN23ZZZ	BN231ZZ	Right wrist	BP0M0ZZ	BP2LZZZ	BP2L1ZZ
Facial	BN05ZZZ	BN25ZZZ	BN251ZZ	Right forearm (radius/ulna)	BP0JZZZ	BP2JZZZ	BP2J1ZZ
Mandible	BN06ZZZ	BN26ZZZ	BN261ZZ	Right elbow	BP0GZZZ	BP2GZZZ	BP2G1ZZ
				Right upper arm (humerus)	BP0AZZZ	BP2AZZZ	BP2A1ZZ
NECK / SPINE				Right shoulder	BP08ZZZ	BP28ZZZ	BP281ZZ
Neck		BW2FZZZ	BW2F1ZZ	Right scapula	BP06ZZZ	BP26ZZZ	BP261ZZ
Cervical spine	BR00ZZZ	BR20ZZZ	BR201ZZ	Left Upper Extremity	BP0FZZZ	BP2UZZZ	BP2U1ZZ
Thoracic spine	BR07ZZZ	BR27ZZZ	BR271ZZ	Left hand	BP0PZZZ	BP2PZZZ	BP2P1ZZ
Lumbosacral spine	BR09ZZZ	BR29ZZZ	BR291ZZ	Left wrist	BP0MZZZ	BP2MZZZ	BP2M1ZZ
				Left forearm (radius/ulna)	BP0KZZZ	BP2KZZZ	BP2K1ZZ
CHEST / ABDOMEN				Left elbow	BP0HZZZ	BP2HZZZ	BP2H1ZZ
Chest	BW03ZZZ	BW24ZZZ	BP241ZZ	Left upper arm (humerus)	BP0BZZZ	BP2BZZZ	BP2B1ZZ
Chest & Abdomen		BW20ZZZ	BW201ZZ	Left shoulder	BP09ZZZ	BP29ZZZ	BP291ZZ
Chest, Abd., Pelvis		BW25ZZZ	BW251ZZ	Left scapula	BP07ZZZ	BP27ZZZ	BP271ZZ
Right Ribs	BP0XZZZ	BP2XZZZ	BP2X1ZZ				
Left Ribs	BP0YZZZ	BP2YZZZ	BP2Y1ZZ	**LOWER EXTREMITIES**	BW0CZZZ		
Sternum	BR0HZZZ			Right Lower Extremity	BQ0DZZZ	BQ2RZZZ	BQ2R1ZZ
Heart / Lung		B226ZZZ	B2261ZZ	Right ankle	BQ0GZZZ	BQ2GZZZ	BQ2G1ZZ
Abdomen		BW20ZZZ	BW201ZZ	Right foot	BQ0LZZZ	BQ2LZZZ	BQ2L1ZZ
Abdomen / Pelvis	BW00ZZZ	BW21ZZZ	BW211ZZ	Right femur	BQ03ZZZ	BQ23ZZZ	BQ231ZZ
				Right knee	BQ07ZZZ	BQ27ZZZ	BQ271ZZ
Kidneys (KUB)	BT03ZZZ	BT23ZZZ	BT231ZZ	Right tibia/fibula	BQ0DZZZ	BQ2BZZZ	BQ2B1ZZ
Right Kidney	BT01ZZZ	BT21ZZZ	BT211ZZ	Right hip	BQ00ZZZ	BQ20ZZZ	BQ201ZZ
Left Kidney	BT02ZZZ	BT22ZZZ	BT221ZZ	Left Lower Extremity	BQ0FZZZ	BQ2SZZZ	BQ2S1ZZ
				Left ankle	BQ0HZZZ	BQ2HZZZ	BQ2H1ZZ
OTHER				Left foot	BQ0MZZZ	BQ2MZZZ	BQ2M1ZZ
Pelvis	BR0CZZZ	BW2GZZZ	BW2G1ZZ	Left femur	BQ04ZZZ	BQ24ZZZ	BQ241ZZ
Sacrum	BR0FZZZ	BR2FZZZ	BR2F1ZZ	Left knee	BQ08ZZZ	BQ28ZZZ	BQ281ZZ
Skeletal Survey	BW0LZZZ			Left tibia/fibula	BQ0FZZZ	BQ2CZZZ	BQ2C1ZZ
				Left hip	BQ01ZZZ	BQ21ZZZ	BQ211ZZ

Additional Information

- Head CT results are **NOT** considered abnormal if facial fracture(s) is / are the only abnormality identified.
- The codes for CT's **with contrast** are for **Low Osmolar Contrast**.
- For CTs using **Other Contrast**, replace the Approach Code of **1** (5th Digit) with **Y**.

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Comments / Results

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY: Study

Definition

Type of radiological study performed during hospital stay that were essential to the diagnosis of patient's specific injuries, if applicable.

Field Values

LA COUNTY	
CT ANGIO	CT Angio
CONTRAST	Contrast Studies
CT SCAN	Computerized Tomography Scan
FAST	Focused Assessment Sonography for Trauma
MRI	Magnetic Resonance Imaging
MRI ANGIO	Magnetic Resonance Imaging(MRI) Angio
PLAIN FILMS	Plain Films
RADIONUCLEOTIDE SCANS	Radionucleotide Scans
ULTRASOUND	Ultrasound
OT	Other study

Additional Information

- Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's injuries.
- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Record subsequent radiology studies identifying missed injuries.
- CTs and MRIs may or may not include contrast.
- If no contrast is used, use the field values of CT Scan and MRI.
- If contrast is used, use the field values of CT Angio or MRI Angio.
- Interventional Angiogram (Catheter Angiogram, Formal Angiogram) involves interventional radiology (IR). IR is considered invasive; therefore, IR procedures should be coded in the procedure section not in the radiology section. A catheter is inserted into an artery or vein through a small incision, and is moved directly into the artery being studied. X-ray images can be obtained while contrast is delivered directly into the artery being studied and allows for embolization if needed.

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Comments / Results

Data Format: [character, 25] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

RADIOLOGY: Date

Definition

Date that x-ray, CAT scan, and/or ultrasound studies were performed, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Time
- RADIOLOGY: Comments / Results

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

RADIOLOGY: Time

Definition

Time that x-ray, CAT scan, and/or ultrasound studies were performed, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Comments / Results

Data Format: [time] multiple entries **Picklist:** No
Min Value: N/A **Max Value:** 2359 **Accepts Null Value:** Yes

RADIOLOGY: Comments / Results

Definition

Results of x-ray, CAT scan, and/or ultrasound studies, if applicable.

Field Values

- A Abnormal
- N Normal

Additional Information

- Head CT results are **NOT** considered abnormal if facial fracture(s) is / are the only abnormality identified.

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Part
- RADIOLOGY: Study
- RADIOLOGY: Date
- RADIOLOGY: Time

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

SOLID ORGAN INJURY?

Definition

Indicate if a solid organ injury exists.

Field Values

- Yes
- No

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGAN GRADING - LIVER

Definition

Results of Solid Organ Grading of the liver, if applicable.

Field Values

LA COUNTY		
Grade I	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
Grade II	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <10cm diameter
	Laceration	1-3cm parenchymal depth, <10cm length
Grade III	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >10cm or expanding
	Laceration	>3cm parenchymal depth
Grade IV	Laceration	Parenchymal disruption involving 25-75% of hepatic lobe 1-3 Couinaud's segments in a single lobe
Grade V	Laceration	Parenchymal disruption involving >75% of hepatic lobe >3 Couinaud's segments within a single lobe
	Vascular	Juxtahepatic venous injuries i.e., retrohepatic vena cava/central major hepatic veins
Grade VI	Vascular	Hepatic Avulsion

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- SOLID ORGAN INJURY?
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

ORGAN GRADING - SPLEEN

Definition

Results of Solid Organ Grading of the spleen, if applicable.

Field Values

LA COUNTY		
Grade I	Hematoma	Subcapsular, <10% surface area
	Laceration	Capsular tear, <1cm parenchymal depth
Grade II	Hematoma	Subcapsular, 10-50% surface area Intraparenchymal, <5cm diameter
	Laceration	1-3cm parenchymal depth not involving a parenchymal vessel
Grade III	Hematoma	Subcapsular, >50% surface area or expanding Ruptured subcapsular or parenchymal hematoma Intraparenchymal hematoma >5cm
	Laceration	>3cm parenchymal depth or involving trabecular vessels
Grade IV	Laceration	Laceration of segmental or hilar vessels producing major devascularization (>25% of spleen)
Grade V	Laceration	Completely shattered spleen
	Vascular	Hilar vascular injury which devascularized the spleen

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – RIGHT KIDNEY
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

ORGAN GRADING – RIGHT KIDNEY

Definition

Results of Solid Organ Grading of the right kidney, if applicable.

Field Values

LA COUNTY		
Grade I	Contusion	Microscopic or gross hematuria, urological studies normal
	Hematoma	Subcapsular, nonexpanding without parenchymal laceration
Grade II	Hematoma	Nonexpanding perirenal hematoma confined to renal retroperitoneum
	Laceration	<1cm parenchymal depth of renal cortex without urinary extravasation
Grade III	Laceration	>1cm depth of renal cortex, without collecting system rupture or urinary extravasation
Grade IV	Laceration	Parenchymal laceration extending through the renal cortex, medulla and collecting system
	Vascular	Main renal artery or vein injury with contained hemorrhage
Grade V	Laceration	Completely shattered kidney
	Vascular	Avulsion of renal hilum which devascularizes the kidney

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – LEFT KIDNEY

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

ORGAN GRADING – LEFT KIDNEY

Definition

Results of Solid Organ Grading of the left kidney, if applicable.

Field Values

LA COUNTY		
Grade I	Contusion	Microscopic or gross hematuria, urological studies normal
	Hematoma	Subcapsular, nonexpanding without parenchymal laceration
Grade II	Hematoma	Nonexpanding perirenal hematoma confined to renal retroperitoneum
	Laceration	<1cm parenchymal depth of renal cortex without urinary extravasation
Grade III	Laceration	>1cm depth of renal cortex, without collecting system rupture or urinary extravasation
Grade IV	Laceration	Parenchymal laceration extending through the renal cortex, medulla and collecting system
	Vascular	Main renal artery or vein injury with contained hemorrhage
Grade V	Laceration	Completely shattered kidney
	Vascular	Avulsion of renal hilum which devascularizes the kidney

Data Source Hierarchy

1. Radiology Records
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- RADIOLOGY: Body Region / Study
- RADIOLOGY: Date
- RADIOLOGY: Time
- RADIOLOGY: Result
- SOLID ORGAN INJURY?
- ORGAN GRADING – LIVER
- ORGAN GRADING – SPLEEN
- ORGAN GRADING – RIGHT KIDNEY

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 5 **Accepts Null Value:** Yes

LABORATORY: Group / Panel

Definition

Type of laboratory testing performed, if applicable.

Field Values

- 24 HOUR URINALYSIS
- BLD BNK - TYPE AND CROSS
- BLD BNK - TYPE AND HOLD
- BLOOD GAS
- CARDIAC ENZYME FRACTIONS
- CEREBROSPINAL FLUID
- CHEMISTRY
- COAGULATION STUDIES
- CULTURES
- ELECTROLYTES
- HEMATOLOGY
- PERITONEAL LAVAGE
- SEROLOGY STUDIES
- SPECIAL CHEMISTRY
- URINALYSIS

Additional Information

- Hemoglobin / Hematocrit are mandatory values if performed.
- Scrolling window fields: enter time, group/panel, description and results for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Result
- LABORATORY: Description *(optional)*

Data Format: [character, 5] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LABORATORY: Date

Definition

Date laboratory testing was performed, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Scrolling window fields: enter date, time, group/panel, description and results for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- LABORATORY: Group/Panel
- LABORATORY: Time
- LABORATORY: Results
- LABORATORY: Description *(optional)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

LABORATORY: Time

Definition

Time laboratory testing was performed, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Scrolling window fields: enter time, group/panel, description and results for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- LABORATORY: Group/Panel
- LABORATORY: Date
- LABORATORY: Results
- LABORATORY: Description *(optional)*

Data Format: [time] multiple entries **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

LABORATORY: Results

Definition

These fields indicate results of laboratory testing performed, if applicable.

Field Values

- A ABNORMAL
- N NORMAL

Additional Information

- Scrolling window fields: enter time, group/panel, description and results for each test as applicable.
- Detailed laboratory test and value fields can be found by clicking on the “Other Labs” button.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- LABORATORY: Group/Panel
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Description *(optional)*

Data Format: [number, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LABORATORY: Description

Definition

Comments or additional information pertaining to laboratory testing performed.

Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, group/panel, description and results for each test as applicable.
- OPTIONAL FIELD: This field may be used for free text comments at the discretion of each treating facility.
- Detailed laboratory test and value fields can be found by clicking on the “Other Labs” button.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- LABORATORY: Group/Panel
- LABORATORY: Date
- LABORATORY: Time
- LABORATORY: Result

Data Format: [character, 50] multiple entries **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ETOH / TOX: Date

Definition

Date specified toxicology testing occurred, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Time
- ETOH /TOX: Substance
- ETOH /TOX: Source
- ETOH /TOX: Results
- ETOH /TOX: Value

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ETOH / TOX: Time

Definition

Time specified toxicology testing occurred, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Date
- ETOH /TOX: Substance
- ETOH /TOX: Source
- ETOH /TOX: Results
- ETOH /TOX: Value

Data Format: [time] multiple entries **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

ETOH / TOX: Substance

Definition

These fields indicate whether or not specified toxicology testing occurred, and if applicable, the times and results of the tests.

Field Values

LA COUNTY		
Acetaminophen (Tylenol)	Narcotics / Opioids	Chlorzoxazone Parafon Forte
Amphetamines / Methamphetamines	Codeine	Diphenhydramine Benadryl
Antipsychotics / Antidepressants	Fentanyl Sublimaze	Doxylamine Unisom
Phenothiazines	Heroin	Hydroxyzine Atarax
Other Antipsychotics	Hydrocodone Vicodin	Isopropanol Rubbing alcohol
Tricyclic Antidepressants	Hydromorphone Dilaudid	Ketamine Ketalar
MAO Inhibitor Antidepressants	Meperidine Demerol	Lidocaine Xylocaine
Other Antidepressants	Methadone	Meprobamate Equanil
Benzodiazepines	Morphine	Methanol
Clonazepam Clonipin	Oxycodone Percodan	Methapyrilene Histadyl
Flurazepam Dalmane	Propoxyphine Darvon	Methocarbamol Robaxin
Lorazepam Ativan	Other Narcotic/Opioid	Phenylpropanolal Dexatrim
Oxazepam Serax	NSAIDS (Motrin)	Phenytoin Dilatin
Prazepam Centrax	PCP	Prochlorperazin Compazine
Other Benzodiazepines	Salicylate (Aspirin)	Pyrilamine Rynatan
Barbiturates	Other toxins	Quinidine
Cannabinoids	Acetone	Theophylline
Cocaine	Caffeine NoDoz	Other Toxin
Ethanol (ETOH)	Carbamazepine Tegretol	Toxicology Screen

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.
- Use Substance value “Toxicology Screen” with Result (see RL_15) of “Not Found” for negative toxicology screens.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Date
- ETOH /TOX: Time
- ETOH /TOX: Source
- ETOH /TOX: Results
- ETOH /TOX: Value

Data Format: [character, 20] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ETOH / TOX: Source

Definition

Specimen type used for toxicology testing, if applicable.

Field Values

- Blood
- Urine

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Date
- ETOH /TOX: Time
- ETOH /TOX: Substance
- ETOH /TOX: Results
- ETOH /TOX: Value

Data Format: [character, 5] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ETOH / TOX: Results

Definition

These fields indicate whether or not specified toxicology testing occurred, and if applicable, findings.

Field Values

- FOUND
- NOT FOUND
- NOT TESTED

LA COUNTY	NTDB
N/A (use F6)	N/A (use null value)
ETOH Result “NOT TESTED”	ED_15 = “1 No ”
ETOH Result “NOT FOUND”--	ED_15 = “2 No (confirmed by test)”
ETOH Result “FOUND”	ED_15 = “3 Yes (confirmed by test, trace levels)”
N/A (no interpretation)	ED_15 = “4 Yes (confirmed by test, > legal limit)”
TOX (BLD) Result “NOT TESTED”	ED_16 = “1 No (by test or not suspected)”
TOX (URINE) Result “NOT TESTED”	ED_16 = “1 No (by test or not suspected)”
TOX (BLD Result “FOUND”	ED_16 = “3 Yes (confirmed by test, prescription)”
TOX (URINE Result “FOUND”	ED_16 = “3 Yes (confirmed by test, prescription)”
TOX (BLD) Result “NOT FOUND”	ED_16 = “1 No (by test or not suspected)”
TOX (URINE) Result “NOT FOUND”	ED_16 = “1 No (by test or not suspected)”
N/A (no interpretation)	ED_16 = “2 Yes (suspected)”
N/A (no interpretation)	ED_16 = “4 Yes (confirmed by test, illegal use)”

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.
- Toxicology screens positive for substance administered during the medical care provided e.g. morphine for pain, are still entered as positive.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Date
- ETOH /TOX: Time
- ETOH /TOX: Substance
- ETOH /TOX: Source
- ETOH /TOX: Value

Data Format: [character, 10] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ETOH / TOX: Value

Definition

Numeric value for toxicology results, if applicable.

Field Values Field Values

- Relevant value for data element

Additional Information

- Scrolling window fields: enter time, specimen source, substance, results and comments for each test as applicable.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon studies performed.
- Provides documentation of assessment.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ETOH /TOX: Date
- ETOH /TOX: Time
- ETOH /TOX: Substance
- ETOH /TOX: Source
- ETOH /TOX: Results

Data Format: [number, 12] multiple entries **Picklist:** No
Min Value: 0 **Max Value:** 99999999.999 **Accepts Null Value:** Yes

DRUGS OF ABUSE

Definition

If applicable, drugs known to be abused by patient at time of injury **(on TPS form only)**.

Field Values

LA COUNTY	
Amphetamine	Cocaine
Barbiturates	Opiates
Cannabinoids	PCP
Other	

Additional Information

- OPTIONAL FIELD on TPS form only – laboratory toxicological findings positive for Amphetamines, Barbiturates, PCP, Cocaine, Opiates, Cannabinoids, or Other substances are recorded on the Radiology/Laboratory screen in the ETOH/Toxicology scrolling window fields.

Data Source Hierarchy

1. Lab results
2. ED Records

Uses

- Allows data to be sorted based upon substances abused by patient at time of injury.

Other Associated Elements

- TOX (BLOOD) fields
- TOX (URINE) fields

Data Format: N/A (TPS Form only) **Picklist:** N/A (TPS Form only)
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** N/A (TPS Form only)

MTP ACTIVATED?

Definition

Indicates whether or not the Massive Transfusion Protocol (MTP) was activated during the care of the patient.

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TQIP BLOOD INCLUSION?

Definition

Indicates whether the patient received blood during the first four hours of ED/hospital arrival.

Field Values

- Yes
- No

Additional Information

- If no blood given, the TQIP BLOOD INCLUSION is equal to “No”.

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records
3. Physician’s Progress Notes
4. Operative Report

Uses

- Identifies patients that received blood.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MTP ACTIVATED?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LOWEST ED / HOSPITAL BP-SYSTOLIC

Definition

Numeric value of the patient's lowest sustained (>5min) systolic blood pressure **within the first hour** of ED/hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

- Up to three-digit numeric value

Additional Information

- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion.

Data Source Hierarchy

1. Trauma Flow Sheet
2. ED Records
3. Physician's Progress Notes
4. Operative Report

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: {character, 3} single entry **Picklist:** No
Min Value: 0 **Max Value:** 300 **Accepts Null Value:** Yes

PACKED CELLS *(4 HOURS)*

Definition

Total volume of packed cells received by the patient during the first **4 hours** of care.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then the volume is zero.
- Packed red blood cells *(4 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA (FFP) *(4 HOURS)*

Definition

Total volume of fresh frozen plasma received by the patient during the first **4 hours** of care.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then the volume is zero.
- Plasma *(4 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(4 HOURS)*

Definition

Total volume of platelets received by the patient during the first **4 hours** of care.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given in the first 24 hours, then the volume is zero.
- Platelets *(4 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(4 HOURS)*

Definition

Total volume of cryoprecipitate received by the patient during the first **4 hours** of care.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED/HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then the volume is zero.
- Cryoprecipitate *(4 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PACKED CELLS *(24 HOURS)*

Definition

Total volume of packed cells received by the patient during the first **24 hours** of care.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given in the first 24 hours, then the volume is zero.
- Packed red blood cells *(24 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA (FFP) *(24 HOURS)*

Definition

Total volume of fresh frozen plasma received by the patient during the first **24 hours** of care.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given in the first 24 hours, then the volume is zero.
- Plasma *(24 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(24 HOURS)*

Definition

Total volume of platelets received by the patient during the first **24 hours** of care.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given in the first 24 hours, then the volume is zero.
- Platelets *(24 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(24 HOURS)*

Definition

Total volume of cryoprecipitate received by the patient during the first **24 hours** of care.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given in the first 24 hours, then the volume is zero.
- Cryoprecipitate *(24 HOURS)* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies treatment for presumed coagulopathy.
- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PACKED CELLS *(TOTAL {includes ED})*

Definition

Total volume of packed cells received by the patient **while hospitalized** – *including* 24 hour total.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Packed Red Blood Cells** 1 unit is equivalent to **350mls** if the actual volume of the unit is not documented.
- If no packed red blood cells were given during the patient’s hospital stay, then the volume is zero.
- Packed Red Blood Cells *(TOTAL {includes ED})* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLASMA (FFP) *(TOTAL {includes ED})*

Definition

Total volume of fresh frozen plasma received by the patient **while hospitalized** – *including* 24 hour total.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Plasma** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no plasma was given during the patient’s hospital stay, then the volume is zero.
- Plasma *(TOTAL {includes ED})* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PLATELETS *(TOTAL {includes ED})*

Definition

Total volume of platelets received by the patient **while hospitalized** – *including* 24 hour total.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Platelets** 1 unit is equivalent to **225mls** if the actual volume of the unit is not documented.
- If no platelets were given during the patient’s hospital stay, then the volume is zero.
- Platelets *(TOTAL {includes ED})* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CRYOPRECIPITATE *(TOTAL {includes ED})*

Definition

Total volume of cryoprecipitate received by the patient **while hospitalized** – *including* 24 hour total.

Field Values

- Relevant value for data element

Additional Information

- Collected in milliliters or units.
- If collected in milliliters, then the MEASUREMENT value is “mls”, and the conversion value is *“Not Applicable”*.
- If collected in units, then the MEASUREMENT value is “units”, and the conversion value is hospital specific unless the standard noted below is used.
- **Cryoprecipitate** pack is equivalent to **100mls** if the actual volume of the pack is not documented.
- If no cryoprecipitate was given during the patient’s hospital stay, then the volume is zero.
- Cryoprecipitate *(TOTAL {includes ED})* volume should never be *“Not Applicable”*.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Total Blood Products.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

MEASUREMENT

Definition

The measurement used to document the patient's specific blood components (PRBCs, Plasma, Platelets, and Cryoprecipitate) transfused while hospitalized.

Field Values

- mls
- unit

Additional Information

- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion.
- The null value *"Not Applicable"* is used if no specific blood components were transfused.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients that received blood.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

CONVERSION

Definition

The quantity of milliliters constituting a “unit” for the specific blood components (PRBCs, Plasma, Platelets, and Cryoprecipitate) at your hospital.

Field Values

- Relevant value for data element

Additional Information

- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion.
- The null value *"Not Applicable"* is used if no specific blood components were transfused.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Identifies patients that received blood.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA (FFP) *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA (FFP) *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA (FFP) *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

TOTAL PRODUCTS

Definition

Total blood/products, packed cells, plasma, platelets, and cryoprecipitate given to the patient **while hospitalized** – *including* 24 hour total.

Field Values

- Relevant value for data element

Additional Information

- Auto-calculated using sum of PACKED CELLS *(TOTAL {includes ED})*, PLASMA *(TOTAL {includes ED})*, PLATELETS *(TOTAL {includes ED})*, and CRYOPRECIPITATE *(TOTAL {includes ED})* values.
- TOTAL PRODUCTS does not appear as a field value on the Trauma Patient Summary form.

Data Source Hierarchy

1. ED Records
2. Blood Bank Records
3. Transfusion Records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.
- Included in calculation of Hospital Blood Totals.

Other Associated Elements

- MTP ACTIVATED?
- TQIP BLOOD INCLUSION?
- LOWEST ED / HOSPITAL BP - SYSTOLIC
- PACKED CELLS *(4 HOURS)*
- PLASMA *(4 HOURS)*
- PLATELETS *(4 HOURS)*
- CRYOPRECIPITATE *(4 HOURS)*
- PACKED CELLS *(24 HOURS)*
- PLASMA *(24 HOURS)*
- PLATELETS *(24 HOURS)*
- CRYOPRECIPITATE *(24 HOURS)*
- PACKED CELLS *(TOTAL {includes ED})*
- PLASMA *(TOTAL {includes ED})*
- PLATELETS *(TOTAL {includes ED})*
- CRYOPRECIPITATE *(TOTAL {includes ED})*
- TOTAL PRODUCTS *(TOTAL {includes ED})*
- MEASUREMENT
- CONVERSION

Data Format: [number, 5] single entry **Picklist:** No
Min Value: 0 **Max Value:** 99999 **Accepts Null Value:** Yes

PROCEDURES / OPERATIONS

PHASE BEGUN

Definition

Phase of care where operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun.

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, Interventional Radiology, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Additional Information

- Operative and/or essential procedures are defined as procedures performed in the Operating Room, Emergency Department, Intensive Care Unit, or radiology department that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries or complications.
- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Use "Readmit" phase of care for procedures done following readmission.

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records

Uses

- Allows data to be sorted based upon procedures performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [character, 8] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

START DATE

Definition

Date when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. OR Records
2. Radiology Records
3. ED Records
4. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with procedures performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START / CUT TIME
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

START / CUT TIME

Definition

Time when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications were begun.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. OR Records
2. Radiology Records
3. ED Records
4. Progress Notes

Uses

- Allows data to be sorted based upon times associated with procedures performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

END TIME

Definition

Time when operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications ended (if relevant).

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon times associated with procedures performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PROCEDURES *(ICD-10 Codes)*

Definition

Operative or essential major and minor procedures conducted during hospital stay that were essential to the stabilization or treatment of the patient's specific injuries or complications.

Field Values

MANDATORY PROCEDURES	ICD-10 CODES	MANDATORY PROCEDURES	ICD-10 CODES
Central Line Approach: • Chest, Open • Chest, Percutaneous **Special Note:** The ICD-10 Code for central lines varies depending on the site and the approach used for placement.	0JH60XZ 0JH63XZ	Inferior Vena Cava (IVC) Filters (temporary or permanent) Approach: • Open • Percutaneous • Percutaneous Endoscopic	06H00DZ 06H03DZ 06H04DZ
Chest Tube (left)	0W9B30Z	Interventional Angiogram (IA) **Special Note:** The ICD-10 Code for IA varies depending on the site and the approach used.	
Chest Tube (right)	0W9930Z		
Cricothyroidotomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0B110F4 0B113F4 0B114F4	Intracranial Pressure (ICP) Monitor: • Percutaneous • Via Natural or Artificial Opening	4A103BD 4A107BD
Diagnostic Peritoneal Aspirate (DPA)	0W9G3ZX	Percutaneous Endoscopic Gastrostomy (PEG) Approach: • Percutaneous • Percutaneous Endoscopic	0DH63UZ 0DH64UZ
Diagnostic Peritoneal Lavage (DPL)	3E1M38X		
Embolization: **Special Note:** The ICD-10 Code for embolization varies depending on the site embolized and the approach used.		Thoracotomy	02JA0ZZ
		Tracheostomy Approach: • Open • Percutaneous • Percutaneous Endoscopic	0BH10DZ 0BH13DZ 0BH14DZ
Endotracheal (ETT) Intubation: • Via Natural or Artificial Opening • Via Natural or Artificial Opening Endoscopic	0BH17EZ 0BH18EZ	Ventilator: • Less than 24 Consecutive Hours • 24-96 Consecutive Hours • > 96 Consecutive Hours	5A1935Z 5A1945Z 5A1955Z

Additional Information

- Operative and/or essential procedures is defined as procedures performed in the OR, ED, ICU, or radiology department that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries.
- Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure).
- Optional operative or essential major and minor procedures ICD-10-CM codes conducted during hospital stay include the following: Licox, Bronchoscopy, & PICC line.

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records
6. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon procedures performed.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [character, 6] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOTAL VENTILATOR DAYS

Definition

The total number of patient days spent on a mechanical ventilator (include all episodes).

Field Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day entered as one full day.
- Excludes mechanical ventilation time associated with operating department procedures and the immediate recovery period.
- A ventilator required for up to 6 hours post-operatively is considered routine and should not be counted as ventilator days.
- Ventilator ICD-9 4th digit is determined by the duration of mechanical duration, e.g. **unspecified** (96.7**0**), **less than 96 consecutive hours** (96.7**1**), or **96 consecutive hours or greater** (96.7**2**).
- If no ventilator episodes recorded, utilize *"Not Applicable"* versus the numeric value of "0".
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilatory days.

Data Source Hierarchy

1. ED Records
2. ICU Records
3. Respiratory Therapy Records
4. Progress Notes

Uses

- Allows data to be sorted based upon days spent on mechanical ventilation.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE
- MD CODE

Data Format: [number, 4] single entry **Picklist:** No
Min Value: 0 **Max Value:** 9999 **Accepts Null Value:** Yes

SURGERY TYPE

Definition

Two-digit numerical code for the type of surgical procedure performed in the operating room.

Field Values

- 00 Surgical Procedures done outside of the operating room
- 01 Orthopedic
- 02 Thoracic
- 03 Abdominal
- 04 Cardiovascular
- 05 Plastics
- 06 Urology
- 07 Vascular
- 08 Neurosurgical – Head
- 09 Neurosurgical – Spine
- 10 Obstetrics / Gynecology
- 11 Ophthalmology
- 99 Other

Data Source Hierarchy

1. OR Reports
2. Anesthesia Record

Uses

- Allows data to be sorted based upon type of surgery performed.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- MD CODE

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

Definition

Name or code of surgeon that performed the surgical procedure in the operating room.

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text physician name or code at discretion of facility.

Data Source Hierarchy

1. OR Records

Uses

- Allows data to be sorted based upon physician performing surgical procedure.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHASE BEGUN
- START DATE
- START / CUT TIME
- END TIME
- PROCEDURES *(ICD-10 Codes)*
- TOTAL VENTILATOR DAYS
- SURGERY TYPE

Data Format: [character, 15] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ANGIOGRAPHY

Definition

Interventional angiogram with or without embolization within the first 24 hours of ED / Hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- None
- Angiogram Only
- Angiogram with Embolization

Additional Information

- Limit collection of angiography data to the first 24 hours following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion.
- Excludes CTA.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ANGIOGRAPHY DATE
- ANGIOGRAPHY TIME
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ANGIOGRAPHY DATE

Definition

Date the interventional angiogram was performed with or without embolization within the first 24 hours of ED / Hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Limit collection of angiography data to the first 24 hours following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion and for those who did not undergo an angiography.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ANGIOGRAPHY
- ANGIOGRAPHY TIME
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ANGIOGRAPHY TIME

Definition

Interventional angiogram with or without embolization within the first 24 hours of ED / Hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Limit collection of angiography data to the first 24 hours following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion and for those who did not undergo an angiography.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ANGIOGRAPHY
- ANGIOGRAPHY DATE
- EMBOLIZATION SITE
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

EMBOLIZATION SITE

Definition

Organ / site of embolization for hemorrhage control.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- Liver
- Spleen
- Kidneys
- Pelvic (iliac, gluteal, obturator)
- Retroperitoneum (lumbar, sacral)
- Peripheral vascular (neck, extremities)
- Aortic (thoracic, abdominal)
- Other

Additional Information

- **Limit collection of embolization site to the first 24 hours** following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion and for those patients who underwent an angiography but without embolization.
- Select all applicable sites.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ANGIOGRAPHY
- ANGIOGRAPHY DATE
- ANGIOGRAPHY TIME
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HEMORRHAGE CONTROL TYPE

Definition

Type of surgery for hemorrhage control within the first 24 hours of ED / hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- None
- Laparotomy
- Thoracotomy
- Sternotomy
- Extremity
- Neck
- Mangled extremity / traumatic amputation
- Other skin / soft tissue

Additional Information

- If unclear if surgery was for hemorrhage control, consult with the Trauma Medical Director or relevant surgeon.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion.
- Select all applicable values.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HEMORRHAGE CONTROL DATE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: {character, 30} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

HEMORRHAGE CONTROL DATE

Definition

Date of surgery for hemorrhage control within the first 24 hours of ED / hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Limit collection of data to the first 24 hours following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion and for those who did not undergo hemorrhage control surgery.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL TIME
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

HEMORRHAGE CONTROL TIME

Definition

Time of surgery for hemorrhage control within the first 24 hours of ED / hospital arrival.

Collection Criterion

COLLECT ON ALL PATIENTS WITH TRANSFUSED PACKED RED BLOOD CELLS WITHIN THE FIRST 4 HOURS OF ED / HOSPITAL ARRIVAL.

Field Values

- Relevant value for data element.

Additional Information

- Collected as HHMM (military time).
- Limit collection of data to the first 24 hours following ED / hospital arrival.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criterion and for those who did not undergo hemorrhage control surgery.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Progress Notes

Uses

- Identifies patients with active bleeding.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HEMORRHAGE CONTROL TYPE
- HEMORRHAGE CONTROL DATE
- MTP ACTIVATED?
- PACKED CELLS *(4 HOURS)*

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PHASE AFTER OR

Definition

Phase of care occurring directly following each OR phase.

Field Values

- 23HR OBS <24 Hour Observation
- ICU Intensive/Critical Care Unit
- INTERVENTIOANL RADIOLOGY
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- SPECIAL PROCEDURES
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor
- POSTHOSPITAL

Data Source Hierarchy

1. Progress Notes
2. ICU records

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- DISCHARGE DATE
- DISCHARGE TIME

Data Format: [character, 17] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ICU / ACUTE CARE

ICU ARRIVAL DATE

Definition

Date patient was admitted to the Intensive Care Unit.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with ICU stays.
- Used to calculate ICU – LENGTH OF STAY (LOS)
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ICU EXIT DATE
- ICU – LENGTH OF STAY (LOS)

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ICU EXIT DATE

Definition

Date patient was discharged or transferred from the Intensive Care Unit.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Uses

- Allows data to be sorted based upon dates associated with ICU stays.
- Used to calculate ICU – LENGTH OF STAY (LOS)
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ICU ARRIVAL DATE
- ICU – LENGTH OF STAY (LOS)

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

ICU - LENGTH OF STAY (LOS)

Definition

The total number of patient days in any ICU (including all episodes).

Field Values

- Relevant value for data element

Additional Information

- Recorded in full day increments with any partial day listed as a full day.
- Field allows for multiple admission and discharge dates and auto-populates the total ICU LOS.
- ICU LENGTH OF STAY (LOS) does not appear as a field value on the Trauma Patient Summary form.

Data Source Hierarchy

1. ICU Records
2. ED Records
3. Progress Notes

Uses

- Provides a rough estimate of severity of injury and resource utilization.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- ICU ARRIVAL DATE
- ICU EXIT DATE

Data Format: [number, 4] auto-calculated **Picklist:** No
Min Value: 1 **Max Value:** 9999 **Accepts Null Value:** Yes

CONSULT DATE

Definition

Date during hospital stay when physician consultation occurred.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- CONSULTATION – SERVICE
- CONSULTATION – MD CODE

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

CONSULT SERVICE

Definition

Service of physician consulted during hospital stay.

Field Values

LA COUNTY					
ANE	ANESTHESIOLOGY	NEP	NEPHROLOGY	POS	PEDIATRIC ORTHOPEDIC
CAR	CARDIOLOGY	NEU	NEUROLOGY	POT	PED. OTOLARYNGOLOGY
CTS	CARDIOTHORACIC SURGEON	NER	NEURORADIOLOGY	PEP	PEDIATRIC PATHOLOGY
CCI	CRITICAL CARE INTENSIVIST	NES	NEUROSURGEON	PPY	PEDIATRIC PSYCHIATRIST
DEN	DENTAL	OBS	OBSTERICS	PPS	PED. PULM. SPECIALIST
DER	DERMATOLOGY	OPS	OPTHAL. SURGEON	PER	PEDIATRIC RADIOLOGY
EDP	ED PHYS/ATTENDING	ORS	ORAL SURGEON	PES	PEDIATRIC SURGEON
EDR	ED RESIDENT	ORT	ORTHOPEDICS	PUR	PEDIATRIC UROLOGY
END	ENDOCRINOLOGY	ONL	OTHER NOT LISTED	PED	PEDIATRICS
FNM	FAMILY MEDICINE	OTO	OTOLARYNGOLOGY	PHY	PHYSIATRY
GAS	GASTROENTEROLOGY	PAL	PALLIATIVE CARE	PLS	PLASTIC SURGEON
GES	GENERAL SURGEON	PAT	PATHOLOGY	POD	PODIATRY
GER	GERIATRICS	PEA	PEDIATRIC ALLERGY	PTN	PRIMARY TRAUMA NURSE
GYN	GYNECOLOGY	PEC	PEDIATRIC CARDIOLOGY	PSC	PSYCHOLOGY
HAS	HAND SURGEON	PCA	PEDIATRIC CHILD ADVOCACY	PSY	PSYCHIATRY
HEM	HEMATOLOGY	PCS	PED. CARDIOTHOR. SURGEON	PUL	PULMONARY SPECIALIST
HMO	HMO CONSULTANT	PEN	PEDIATRIC ENDOCRINOLOGY	RAD	RADIOLOGY
HNS	HEAD & NECK SURGEON	PEG	PED. GASTROENTEROLOGY	RHE	RHEUMATOLOGY
HBO	HYPERBARIC MEDICINE	PEH	PEDIATRIC HEMATOLOGY	SPI	SPINAL
INF	INFECTIOUS MEDICINE	PEI	PEDIATRIC INTENSIVIST	THS	THORACIC SURGEON
INR	INTERVENT. RADIOLOGY	PMS	PAIN MANAGE SPECIALIST	TRR	TRAUMA RESIDENT
INT	INTERNAL MEDICINE	PNP	PEDIATRIC NEPHROLOGY	TRS	TRAUMA SURG/ATTEND
MAS	MAXILLOFACIAL SURGEON	PNE	PEDIATRIC NEUROLOGY	URO	UROLOGY
NCC	NEURO CRITICAL CARE	PNR	PEDIATRIC NEURORADIOLOGY	VAS	VASCULAR SURGEON
NEO	NEONATOLOGY	PNS	PEDIATRIC NEUROSURGEON		

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Allows data to be sorted based upon physician service.
- Used in quality management for the evaluation of care.

Other Associated Elements

- CONSULTATION – DATE
- CONSULTATION – MD CODE

Data Format: [character, 15] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MD CODE

Definition

Name or code of physician consulted during hospital stay.

Field Values

- Relevant value for data element

Additional Information

- Enter physician name or code directly, or create facility-specific picklist.

Data Source Hierarchy

1. Progress Notes
2. Consultation Notes

Uses

- Allows data to be sorted based upon responding physician.
- Used in quality management for the evaluation of care.

Other Associated Elements

- CONSULTATION – DATE
- CONSULTATION – SERVICE

Data Format: [character, 15] multiple entries **Picklist:** Yes, facility-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TQIP TBI INCLUSION?

Definition

Indicate if patient meets the TQIP TBI inclusion criteria.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Yes
- No

Additional Information

- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Procedure Notes
4. Neurosurgical Notes
5. ICU Records
6. Progress Notes
7. Anesthesia Records
8. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon type of surgery performed.
- Used in quality management for the evaluation of care.

Other Associated Elements

- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INITIAL PUPILLARY RESPONSE

Definition

Physiological response of the pupil size within 30 minutes or less of ED / hospital arrival.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

LA COUNTY		NTDB	
2	Both Reactive	1	Both Reactive
1	One Reactive	2	One Reactive
0	Neither Reactive	3	Neither Reactive

Additional Information

- If a patient does not have a listed field value recorded, but there is documentation related to their pupillary response such as PERRL "Pupils Equal Round Reactive to Light" submit field value for both reactive IF there is no other contradicting documentation.
- One reactive should be reported for patients who have a prosthetic eye.
- The null value "*Not Known/Not Recorded*" should be submitted if this information is not documented or if assessment is unable to be obtained due to facial trauma and/or foreign object in the eye.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 1] multiple entries **Picklist:** Yes, non-modifiable
Min Value: 0 **Max Value:** 2 **Accepts Null Value:** Yes

HIGHEST GCS TOTAL

Definition

Highest total GCS **within 24 hours** of ED / Hospital arrival.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Relevant value for data element

Additional Information

- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after ED discharge.
- If patient is intubated then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [number, 2} single entry **Picklist:** No
Min Value: 3 **Max Value:** 15 **Accepts Null Value:** Yes

HIGHEST GCS MOTOR

Definition

Highest GCS MOTOR **within 24 hours** of ED / Hospital arrival.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- 6 Obeys commands
- 5 Localizes pain
- 4 Withdraws from pain
- 3 Flexion (decorticate movement) to pain
- 2 Extension (decerebrate movement) to pain
- 1 No motor response

Additional Information

- Requires review of all data sources to obtain the highest GCS total. In many cases, the highest GCS may occur after ED discharge.
- If patient is intubated then the GCS Verbal score is equal to 1.
- Best obtained when sedatives or paralytics are withheld as part of sedation holiday.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. Neuro Assessment Flow Sheet
2. Triage/Trauma/ICU Flow Sheet
3. Nursing Notes/Flow Sheet
4. Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [number, 1 single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 6 **Accepts Null Value:** Yes

QUALIFIER OF HIGHEST GCS

Definition

Documentation of factors potentially affecting the highest GCS upon arrival in the ED / hospital.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

LA COUNTY	
O - Obstruction Eye	TS – Intubated & Sedated / Paralyzed
S - Sedated / Paralyzed	TSO – Intubated, Sedated / Paralyzed, & Obstruction
T - Intubated	SO - Sedated / Paralyzed & Obstruction
TO – Intubated & Obstruction	L – Valid GCS, Not sedated, intubated, or obstructed

Additional Information

- Identified medical treatments that may affect the first assessment of GCS. This field does not apply to self-medications the patient may have administered (i.e., ETOH, prescriptions, etc.).
- Requires review of all data sources to obtain the highest GCS motor score which might occur after the ED phase of care.
- Must be the assessment qualifier for the Highest GCS Total.
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agents like succinylcholine, mivacurium, rocuronium, (cis) atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. ED Records
2. Physician's Progress Notes

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

MIDLINE SHIFT?

Definition

Indicate if a midline shift exists (>5mm shift past its center line) within 24 hours after time of injury.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Yes
- No
- Not Imaged

Additional Information

- If there is documentation of "massive" midline shift in lieu of >5mm shift measurement, submit field value 1. Yes.
- Radiological and surgical documentation from transferring facilities should be considered for this data field.
- The null value "Not Known/Not Recorded" is used if both the injury date and injury time are unknown.
- If the injury time is unknown, but there is supporting documentation that the injury occurred within 24-hours of any CT measuring a >5mm shift, report the field value "1. Yes" if there is no other contradicting documentation.
- If the patient was not imaged within 24 hours from the time of injury, report the field value "3. Not Imaged (e.g. CT Scan, MRI)".
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. Radiology Report
2. Operative Report
3. Procedure Notes
4. Neurosurgical Notes
5. ICU Records
6. Progress Notes
7. Anesthesia Records
8. Hospital Discharge Summary

Uses

- Allows data to be sorted based upon type of surgery performed.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CEREBRAL MONITOR TYPE

Definition

If an ICP monitor was placed during the acute phase of care (1ST 72 Hours) indicate the type.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Intraparenchymal Oxygen Monitor (e.g., Licox)
- Intraparenchymal Pressure Monitor (e.g., Camino bolt, subarachnoid bolt)
- Intraventricular Drain/Catheter, draining (e.g., Ventriculostomy, External Ventricular Drain {EVD})
- Jugular Venous Bulb
- None

Additional Information

- Refers to insertion of an intracranial pressure (ICP) monitor (or other measures of cerebral perfusion) for the purposes of managing severe TBI.
- Cerebral monitor placed at a referring facility would be acceptable if such a monitor was used by receiving facility to monitor the patient.
- Selection of the field value of 'none' for the Cerebral Monitor Type, will result in the autofill of "NA" for the Date and Time.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- Field cannot be left blank.

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR DATE
- CEREBRAL MONITOR TIME

Data Format: [character, 2] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CEREBRAL MONITOR DATE

Definition

The date an ICP monitor was placed.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- The null value *"Not Applicable"* is also used if the CEREBRAL MONITOR TYPE is "none".
- Field cannot be left blank.

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

CEREBRAL MONITOR TIME

Definition

If an ICP monitor was placed during the acute phase of care (1ST 72 Hours) indicate the type.

Collection Criterion

- **ONLY COLLECT ON PATIENTS WITH AT LEAST ONE INJURY IN AIS HEAD REGION, excluding patients with isolated scalp abrasion(s), scalp contusion(s), scalp lacerations(s), and scalp avulsion(s).**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is used for patients that do not meet the collection criteria.
- The null value *"Not Applicable"* is also used if the CEREBRAL MONITOR TYPE is "none".
- Field cannot be left blank.

Data Source Hierarchy

1. Operative Report
2. Procedure Notes
3. Neurosurgical Notes
4. ICU Records
5. Progress Notes
6. Anesthesia Records
7. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- TQIP TBI INCLUSION?
- INITIAL PUPILLARY RESPONSE
- HIGHEST GCS TOTAL
- HIGHEST GCS MOTOR
- QUALIFIER OF HIGHEST GCS
- MIDLINE SHIFT?
- CEREBRAL MONITOR TYPE
- CEREBRAL MONITOR DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

TQIP VTE PROPHYLAXIS INCLUSION?

Definition

Indicates if the patient received Venous Thromboembolism (VTE) prophylaxis at your facility.

Collection Criterion

- **COLLECT ON ALL PATIENTS**

Field Values

- Y (Yes)
- N (No)

Additional Information

- Collected as HHMM (military time).
- Field value cannot be *"Not Applicable"*.
- Field cannot be left blank.

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

VTE PROPHYLAXIS TYPE

Definition

Type of Venous Thromboembolism (VTE) prophylaxis first administered to the patient at your facility.

Collection Criterion

- **COLLECT ON ALL PATIENTS.**

Field Values

LA COUNTY		NTDB	
1	Heparin	1	Heparin
2	LMWH (Dalteparin, Enoxaparin, etc.)	6	LMWH (Dalteparin, Enoxaparin, etc.)
3	Direct Thrombin Inhibitor (Dabigatran, etc.)	7	Direct Thrombin Inhibitor (Dabigatran, etc.)
4	Xa Inhibitor (Rivaroxaban, etc.)	8	Xa Inhibitor (Rivaroxaban, etc.)
5	Coumadin	9	Coumadin
6	Other	10	Other
7	None	5	None

Additional Information

- Does not accept null values.
- Field value cannot be *"Not Applicable"*.
- Field value cannot be left blank.

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS DATE
- VTE PROPHYLAXIS TIME

Data Format: [number, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: 1 **Max Value:** 10 **Accepts Null Value:** No

VTE PROPHYLAXIS DATE

Definition

Date VTE prophylaxis first administered to the patient at your facility.

Collection Criterion

- **COLLECT ON ALL PATIENTS.**

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- The null value *"Not Applicable"* is used if no Venous Thromboembolism Prophylaxis Type exists.
- Field value cannot be left blank.

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS TIME

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

VTE PROPHYLAXIS TIME

Definition

Time VTE prophylaxis first administered to the patient at your facility.

Collection Criterion

- **COLLECT ON ALL PATIENTS.**

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- The null value *"Not Applicable"* is used if no Venous Thromboembolism Prophylaxis Type exists.
- Field value cannot be left blank.

Data Source Hierarchy

1. Medication Summary
2. Nursing Notes / Flow Sheet
3. Pharmacy Record

Uses

- Provides documentation of assessment and care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- VTE PROPHYLAXIS INCLUSION?
- VTE PROPHYLAXIS TYPE
- VTE PROPHYLAXIS DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT?

Definition

Care was withdrawn based on a decision to either remove or withhold further life sustaining intervention. This decision **MUST** be documented in the medical record and is often, but not always associated with a discussion with the legal next of kin.

Field Values

- Y (Yes)
- N (No)

Additional Information

- DNR is not a requirement.
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT MUST be documented with the date and time. These interventions are limited to: ventilator support (with or without extubation), dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g. decompressive craniectomy, operation for hemorrhage control, angiography). Note that this definition provides equal weight to the withdrawal of an intervention already in place (e.g. extubation) and a decision not to proceed with a life-saving intervention (e.g. intubation).
- DNR order is not the same as withdrawal of care.
- Field value cannot be left blank.

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Definition

The date care was withdrawn.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Field value cannot be left blank.

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Data Format: [date] single entry
Min Value: 1/1/1979 **Max Value:** current date
Picklist: No
Accepts Null Value: Yes

WITHDRAWAL OF LIFE SUPPORTING TREATMENT TIME

Definition

The time care was withdrawn.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Field value cannot be left blank.

Data Source Hierarchy

1. Progress Notes
2. ICU records
3. Withdrawal of care order
4. Hospital Discharge Summary

Uses

- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- WITHDRAWAL OF LIFE SUPPORTING TREATMENT?
- WITHDRAWAL OF LIFE SUPPORTING TREATMENT DATE

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

POSTHOSPITAL

HOSPITAL DISPOSITION ORDER DATE

Definition

The **date the order was written** for the patient to be transferred or discharged from the hospital, or the date the patient died.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

HOSPITAL DISPOSITION ORDER TIME

Definition

The **time the order was written** for the patient to be transferred or discharged from the hospital, or the date the patient died.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate Hospital LOS.
- Allows data to be sorted based Hospital LOS.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

DISCHARGE DATE

Definition

The date the patient died, was transferred or discharged from the hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

DISCHARGE TIME

Definition

The time the patient died, was transferred or discharged from the hospital.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Used to calculate Hospital LOS.
- Allows data to be sorted based upon Hospital LOS.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

PRIOR PHASE

Definition

Phase of care occurring directly prior to hospital discharge of patient.

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Additional Information

- If the 23HR OBS is not a specific physical location at your facility, utilize Ward/Floor as the phase of care prior to discharge.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon patient's last phase of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED / DISCHARGED TO

Definition

The disposition of the patient when discharged from the hospital.

Field Values

LA COUNTY		NTDB	
ACUTE	Acute Care Facility	1	Transferred to another acute care hospital using EMS
AMA	AMA/Eloped/LWBS	4	Left against medical advice
BURN	Burn Center	1	Transferred to another acute care hospital using EMS
HOME WITH	Home W/Home Hlth Srvcs	3	Discharged home under care of Home Health Agency
HOME W/O	Home Without Services	6	Discharged home with no home services
HOSPICE	Hospice	8	Discharged to hospice care
JAIL	Jail	10	Discharged/Transferred to court/law enforcement
MORGUE	Morgue	5	Expired
REHAB	Rehabilitation Center	11	Transferred to inpatient rehabilitation or designated unit
SCJ	Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
SNF	Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility
SUBACUTE	Subacute Care	2	Transferred to an Intermediate Care Facility
TRAUMA	Trauma Center	1	Transferred to another acute care hospital using EMS
LTCH	Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
PSYCH	Psychiatric Facility	13	Discharged/Transferred to a psych hospital/hospital psych unit
OTHER	Other	14	Discharged/Transferred to another type of facility not defined

Additional Information

- For patients pronounced brain dead and whose care is assumed by an organ procurement agency enter “Morgue”.
- Long-term care hospitals (LTCHs) are certified as acute care hospitals, but focus on patients who, on average, stay more than 25 days.
- An SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides.
- “Home” refers to the patient’s current place of residence, e.g., prison, Child Protective Services, etc.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon post-ED phase of care.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 9] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

FACILITY

Definition

If applicable, the three-letter code for the facility to which the patient was transferred.

Field Values

- See drop-down picklist for all facilities and their codes

Additional Information

- Only applicable for patients transferred (e.g. Acute Care, Burn, Trauma).
- For patients discharged to non-acute care facilities (e.g. Rehab, SNF, Subacute) use “Other”.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Provides documentation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFERRED OUT VIA

Definition

If applicable, method used for transferring the patient.

Field Values

- Air
- Ground

Additional Information

- Only applicable for patients transferred (e.g. Acute Care, Burn, Trauma).
- This field will automatically be filled with *"Not Applicable"* for patients Transferred / Discharged To:
  - AMA/Eloped/LWBS (Left Without Being Seen)
  - Home w/Home Hlth
  - Home w/o
  - Morgue

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Provides documentation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFER RATIONALE
- DISCHARGE CAPACITY

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TRANSFER RATIONALE

Definition

The rationale for transfer, if applicable.

Field Values

LA COUNTY		
CU	In Custody	Patient discharged/transferred in custody of law enforcement
EX	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc.
FI	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
HP	Health Plan	Health Plan decision
OT	Other	Transfer rationale other than above
RH	Rehab	Patient required rehabilitation
SC	Specialized/ Higher Level Care	Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, reimplantation

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon post-ED phase of care.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- DISCHARGE CAPACITY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISCHARGE CAPACITY

Definition

Patient's gross functional capacity upon discharge from hospital.

Field Values

LA COUNTY	
H PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
P PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

Additional Information

- The null value of *"Not Applicable"* is used if the patient expired.
- A splenectomy in NOT considered a permanent handicap.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon functional capacity at discharge.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

PHYSICAL ABUSE REPORTED?

Definition

A report of suspected physical abuse was made to law enforcement and/or protective services.

Field Values

- Y (Yes)
- N (No)

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.
- If PHYSICAL ABUSE REPORTED? is “Yes”, then INVESTIGATION INITIATED and CAREGIVER CHANGE must be completed.
- Field value cannot be *“Not Applicable”*.
- Field value cannot be left blank.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse.
- Used in quality management for the evaluation of care.

Other Associated Elements

- INVESTIGATION INITIATED?
- CAREGIVER CHANGE?

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

INVESTIGATION INITIATED?

Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.

Field Values

- Y (Yes)
- N (No)

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.
- If PHYSICAL ABUSE REPORTED? is “Yes”, then INVESTIGATION INITIATED and CAREGIVER CHANGE must be completed.
- If PHYSICAL ABUSE REPORTED? is “No”, then INVESTIGATION INITIATED will auto fill with “*Not Applicable*”.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHYSICAL ABUSE REPORTED?
- CAREGIVER CHANGE?

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CAREGIVER CHANGE?

Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

Field Values

- Y (Yes)
- N (No)

Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.
- If PHYSICAL ABUSE REPORTED? is “Yes”, then INVESTIGATION INITIATED and CAREGIVER CHANGE must be completed.
- If PHYSICAL ABUSE REPORTED? is “No”, then CAREGIVER CHANGE will auto fill with “*Not Applicable*”.

Data Source Hierarchy

1. EMS Run Sheet
2. ED Records
3. History/Physical
4. Progress Notes
5. Case Manager / Social Service’s Notes
6. Hospital Discharge Summary

Uses

- Determine trauma incidents due to physical abuse.
- Used in quality management for the evaluation of care.

Other Associated Elements

- PHYSICAL ABUSE REPORTED?
- INVESTIGATION INITIATED

Data Format: {character, 1} single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

LIVED / DIED

Definition

Indicates whether or not patient died of injuries during hospital stay.

Field Values

- L Lived
- D Died

Data Source Hierarchy

1. Hospital Records
2. Hospital Discharge Summary
3. Progress Notes

Uses

- Allows data to be sorted based upon mortality.
- Used in quality management for the evaluation of care.

Other Associated Elements

- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

AUTOPSY UPDATE?

Definition

Indicates whether or not an autopsy update was provided/obtained.

Field Values

- Y (Yes)
- N (No)

Additional Information

- Enter “Yes” if a Coroner’s Report is received.
- To ensure that the data accurately reflects the extent of the patient’s injuries, enter any additional injuries identified in the autopsy report in the discharge diagnoses.

Data Source Hierarchy

1. Coroner Report

Uses

- Allows data to be sorted according to whether or not autopsy update was obtained.

Other Associated Elements

- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

CORONER

Definition

Coroner's ID number or code, if applicable.

Field Values

- Relevant value for data element

Additional Information

- Non-picklisted – free text Coroner name or code at discretion of facility.

Data Source Hierarchy

1. Trauma Patient Summary Form?

Uses

- Identifies the coroner that performed the autopsy, if applicable.

Other Associated Elements

- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- ORGAN REFERRAL?
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 10] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGAN REFERRAL?

Definition

Indicates whether or not patient was referred for potential organ donation.

Field Values

- Y (Yes)
- N (No)

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes

Uses

- Allows tracking of organ referrals.

Other Associated Elements

- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN DONOR?
- ORGANS DONATED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGAN DONOR?

Definition

Indicates whether or not patient's organs were donated.

Field Values (Organ Donor?)

- Y (Yes)
- N (No)

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes

Uses

- Allows tracking of organ donation.

Other Associated Elements

- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGANS DONATED

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

ORGANS DONATED:

Definition

Indicates which specific organs were donated.

Field Values (Organs Donated)

- Heart
- Intestine
- Kidney (1)
- Kidneys (2)
- Liver
- Lung (1)
- Lungs (2)
- Pancreas

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes

Uses

- Allows tracking of organ donation.

Other Associated Elements

- LIVED / DIED
- HOSPITAL DISPOSITION ORDER DATE
- HOSPITAL DISPOSITION ORDER TIME
- DISCHARGE DATE
- DISCHARGE TIME
- PRIOR PHASE
- TRASFERRED / DISCHARGED TO
- FACILITY
- TRANSFERRED OUT VIA
- TRANSFER RATIONALE
- AUTOPSY UPDATE?
- CORONER #
- ORGAN REFERRAL?
- ORGAN DONOR?

Data Format: [character, 9] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISCHARGE DIAGNOSES – ICD-10 CM CODES

Definition

All identified diagnoses related to injury.

Field Values

- ICD-10-CM codes

Additional Information

- Injury diagnoses as defined by ICD-10 codes range S00-S99, T07, T14, T20-T-28, and T30-T32.
- ICD-10-CM codes should be listed starting with the most to least significant injury.
- The primary injury resulting in the hospitalization should be listed first.
- The “significance” of other injuries should be based upon severity and location.
- Used to calculate AIS and Injury Severity Score.
- To ensure that the data accurately reflects the extent of the patient’s injuries, if a Coroner’s report is received enter any additional injuries identified in the autopsy report.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Billing Sheet / Medical Records Coding Summary Sheet
3. ER , ICU, OR Records
4. Autopsy / Medical Examiner Report

Uses

- Allows characterization of patients and hospital outcomes based upon the presence, severity and type of injury.
- Allows data to be sorted based upon ICD-10-CM codes.
- Provides documentation of care.
- Used in quality management for the evaluation of care.

Other Associated Elements

- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS
- NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 6] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

DISCHARGE DIAGNOSES – ABBREVIATED INJURY SCALE

Definition

The **Abbreviated Injury Scale** (**AIS**) is an anatomical-based coding system to classify and describe the severity of injuries. It represents the threat to life associated with the injury rather than the comprehensive assessment of the severity of the injury.

Field Values

- Relevant value for data element

Additional Information

- The scale describes three aspects of the injury, type, location, and severity using 7 numbers written as 12(34)(56).7

THE NUMBERS 12(34)(56).7 INDICATE THE FOLLOWING:	EXAMPLE: 851814.3, FEMORAL SHAFT FRACTURE
1 – Body Region 1. Head (Cranium & Brain) 2. Face (including eyes & ears) 3. Neck 4. Thorax 5. Abdomen 6. Spine 7. Upper Extremity 8. Lower Extremity 9. External & Other	8 = Body Region: **Lower Extremity**
2 – Type of Anatomic Structure	5 = Type of Anatomic Structure: **Skeletal**
3,4 – Specific Anatomic Structure	18 = Specific Anatomic Structure: **Femur**
5,6 – Level of Injury	14 = Level of Injury: **Shaft**
.7 – AIS: Severity Score (Ranging from 1 {least severe} to 6 {most severe) 1. Minor 2. Moderate 3. Serious 4. Severe 5. Critical 6. Maximal (currently untreatable)	.3 = AIS: Severity Score: **Serious**

- Used to calculate Injury Severity Score.
- To ensure that the data accurately reflects the extent of the patient's injuries, if a Coroner's report is received enter any additional injuries identified in the autopsy report.
- Enter AIS: Severity Score of "9" if it is not possible to assign a severity to an injury.
- Field value cannot be *"Not Applicable".*
- Field cannot be left blank.

Data Source Hierarchy

1. AIS Coding Manual (AIS 05, Update 08)
2. Hospital Discharge Summary
3. Billing Sheet / Medical Records Coding Summary Sheet
4. ER , ICU, OR Records
5. Autopsy / Medical Examiner Report

Uses

- Allows characterization of patients and hospital outcomes based upon the presence, severity and type of injury.
- Allows data to be sorted based upon AIS codes.

Other Associated Elements

- DISCHARGE DIAGNOSES – ICD-10 CM CODES
- NTDS CO-MORBID CONDITIONS
- NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 6] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

NTDS CO-MORBID CONDITIONS

Definition

Pre-existing co-morbid factors present before patient arrival at the ED/hospital.

Field Values

LA COUNTY	NTDB	
No NTDS Co-Morbidities		No NTDS Co-Morbidities are present
Advanced Directive (limiting care) (DNR status)	13	Advanced Directive (limiting care)
Alcoholism	2	Alcohol Use Disorder
Angina (Pectoris)	16	History of Angina within 30 days NTDB RETIRED IN 2017
	32	Angina Pectoris
Anticoagulant Therapy	31	Anticoagulant Therapy
Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)	30	Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)
Bleeding Disorder	4	Bleeding Disorder
Cerebral Vascular Accident (CVA) / Residual Neuro Deficit	10	Cerebral Vascular Accident (CVA)
Chemotherapy (currently receiving)	5	Currently receiving Chemotherapy for cancer
Chronic Obstructive Pulmonary Disease (COPD)	23	Chronic Obstructive Pulmonary Disease (COPD)
Cirrhosis	25	Cirrhosis
Congenital Anomalies	6	Congenital Anomalies
Congestive Heart Failure (CHF)	7	Congestive Heart Failure (CHF)
Current Smoker	8	Current Smoker
Dementia	26	Dementia
Diabetes Mellitus	11	Diabetes Mellitus
Dialysis	9	Chronic Renal Failure
Disseminated Cancer	12	Disseminated Cancer
Drug (Substance) Abuse or Dependence	28	Drug Use Disorder NTDB RETIRED IN 2017
	36	Substance Abuse Disorder
Functionally Dependent Health Status	15	Functionally Dependent Health Status
Hypertension	19	Hypertension
Mental/Personality Disorder	27	Major Psychiatric Illness NTDB RETIRED IN 2017
	33	Mental/Personality Disorder
Myocardial Infarction	17	History of Myocardial Infarction NTDB RETIRED IN 2017
	34	Myocardial Infarction (MI)
Peripheral Arterial Disease (PAD)	35	Peripheral Arterial Disease (PAD)
Prematurity	21	Prematurity
Seizure Disorder	N/A	
Steroid Use	24	Steroid Use
Other:	1	Other

Additional Information

- The field value “No NTDS co-morbidities” should be chosen if none of the pre-existing co-morbid factors listed above are present in the patient.

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon the presence (and type) of co-morbid condition.

Other Associated Elements

- DISCHARGE DIAGNOSES – ICD-10 CM CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS HOSPITAL COMPLICATIONS

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

NTDS HOSPITAL COMPLICATIONS

Definition

Any medical complication that occurred during the patient's stay at your hospital.

Field Values

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Acute Respiratory Distress Syndrome (ARDS)	5	Acute Respiratory Distress Syndrome (ARDS)
Alcohol Withdrawal	13	Drug/Alcohol Withdrawal Syndrome NTDB RETIRED IN 2017
	36	Alcohol Withdrawal Syndrome
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Central Line-Associated Bloodstream Infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Decubitus (Pressure) Ulcer	11	Decubitus Ulcer NTDB RETIRED IN 2017
	37	Pressure Ulcer
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT) /Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Myocardial Infarction	18	Myocardial Infarction
Osteomyelitis	29	Osteomyelitis
Pneumonia Ventilator Associated (VAP)	35	Ventilator Associated Pneumonia
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Sepsis and/or Severe Sepsis	24	Systemic Sepsis NTDB RETIRED IN 2011
	32	Severe Sepsis
Surgical (Incisional) Site Infection (superficial)	23	Superficial Surgical Site Infection NTDB RETIRED IN 2017
	38	Superficial Incisional Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Other:	1	Other

Additional Information

- The field value "No NTDS complications" should be chosen if none of the pre-existing co-morbid factors listed above are present in the patient

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows data to be used to characterize patients and hospital outcomes based upon presence and type of hospital complication.

Other Associated Elements

- DISCHARGE DIAGNOSES – ICD-10 CM CODES
- DISCHARGE DIAGNOSES - ABBREVIATED INJURY SCALE
- NTDS CO-MORBID CONDITIONS

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT

READMIT DATE

Definition

The date the patient was readmitted to the hospital following discharge, elopement, AMA, etc., or readmission post transfer for higher level of care for an unplanned readmission.

Field Values

- Relevant value for data element

Additional Information

- If the patient returns to the ED, enter the date patient the patient returned to the ED. If patient was directly admitted to the hospital, enter date patient was re-admitted to the hospital.
- **Only applicable if patient returns within 30 days of discharge.**
- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. ED Record
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

READMIT TIME

Definition

The time the patient was readmitted to the hospital following discharge, elopement, AMA, etc., or readmission post transfer for higher level of care for an unplanned readmission.

Field Values

- Relevant value for data element

Additional Information

- If the patient was brought back to the ED, enter the time the patient arrived in the ED. If patient was directly admitted to the hospital, enter the time the patient was readmitted to the hospital.
- Collected as HHMM (military time).

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

READMIT COMMENTS

Definition

Comments related to the readmission of the patient.

Field Values

- Free text

Data Source Hierarchy

1. Radiology readings / Lab results
2. ED Records
3. ICU Records
4. Operative Reports
5. Billing Sheet / Medical Records Coding Summary Sheet
6. Hospital Discharge Summary

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 6] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** Unlimited **Accepts Null Value:** Yes

READMIT COMPLICATIONS

Definition

Any medical complication that occurred during the patient's readmission.

Field Values

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Acute Respiratory Distress Syndrome (ARDS)	5	Acute Respiratory Distress Syndrome (ARDS)
Alcohol Withdrawal	13	Drug/Alcohol Withdrawal Syndrome NTDB RETIRED IN 2017
	36	Alcohol Withdrawal Syndrome
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Central Line-Associated Bloodstream Infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Decubitus (Pressure) Ulcer	11	Decubitus Ulcer NTDB RETIRED IN 2017
	37	Pressure Ulcer
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT) /Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Myocardial Infarction	18	Myocardial Infarction
Osteomyelitis	29	Osteomyelitis
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Sepsis and/or Severe Sepsis	24	Systemic Sepsis NTDB RETIRED IN 2011
	32	Severe Sepsis
Surgical (Incisional) Site Infection (superficial)	23	Superficial Surgical Site Infection NTDB RETIRED IN 2017
	38	Superficial Incisional Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Ventilator Associated Pneumonia (VAP)	35	Ventilator Associated Pneumonia
Other:	1	Other

Data Source Hierarchy

1. Progress/Consultation Notes
2. Hospital Nursing Notes

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 22] multiple entries **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT DISCHARGE DATE

Definition

The date the patient died, was transferred or discharged from the hospital following readmission.

Field Values

- Relevant value for data element

Additional Information

- Collected as MM-DD-YYYY.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [date] single entry **Picklist:** No
Min Value: 1/1/1979 **Max Value:** current date **Accepts Null Value:** Yes

READMIT DISCHARGE TIME

Definition

The time the patient died, was transferred or discharged from the hospital following readmission.

Field Values

- Relevant value for data element

Additional Information

- Collected as HHMM (military time).
- Utilize the time the patient was pronounced brain dead in situations when care is assumed by an organ procurement agency.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [time] single entry **Picklist:** No
Min Value: 0000 **Max Value:** 2359 **Accepts Null Value:** Yes

READMIT PRIOR PHASE

Definition

Phase of care prior to discharge of the patient following readmission.

Field Values

- 23HR OBS <24 Hour Observation
- ED Emergency Department
- ICU Intensive/Critical Care Unit
- IR Interventional Radiology
- OR Operating Room
- PICU Pediatric ICU
- PEDSWARD Pediatric Ward
- READMIT
- SPECIAL PROCEDURES (e.g., Angio, etc)
- STEPDOWN Stepdown or Telemetry Unit
- WARD Ward/Floor

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 8] single entry **Picklist:** No
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT TRANSFERRED / DISCHARGED TO

Definition

The disposition of the patient following readmission.

Field Values

LA COUNTY	NTDB	
ACUTE Acute Care Facility	1	Transferred to another acute care hospital using EMS
AMA AMA/Eloped/LWBS	4	Left against medical advice
BURN Burn Center	1	Transferred to another acute care hospital using EMS
HOME WITH Home W/Home Hlth Srvcs	3	Discharged home under care of Home Health Agency
HOME W/O Home Without Services	6	Discharged home with no home services
HOSPICE Hospice	8	Discharged to hospice care
JAIL Jail	10	Discharged/Transferred to court/law enforcement
MORGUE Morgue	5	Expired
REHAB Rehabilitation Center	11	Transferred to inpatient rehabilitation or designated unit
SCJ Jail Ward at LAC+USC	10	Discharged/Transferred to court/law enforcement
SNF Skilled Nursing Facility	7	Transferred to Skilled Nursing Facility
SUBACUTE Subacute Care	2	Transferred to an Intermediate Care Facility
TRAUMA Trauma Center	1	Transferred to another acute care hospital using EMS
LTCH Long Term Care Hospital	12	Discharged/Transferred to Long Term Care Hospital (LTCH)
PSYCH Psychiatric Facility	13	Discharged/Transferred to a psych hospital or a hospital psych unit
OTHER Other	14	Discharged/Transferred to another type of institution not defined

Additional Information

- Utilize morgue for patient's pronounced brain dead and care is assumed by an organ procurement agency.
- Long-term care hospitals (LTCHs) are certified as acute care hospitals, but focus on patients who, on average, stay more than 25 days.
- An SNF is an institution that provides skilled nursing care after a patient no longer needs the level of services that an acute care hospital provides.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT RATIONALE
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 9] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT RATIONALE

Definition

The rationale for transfer following readmission, if applicable.

Field Values

LA COUNTY		
CU	In Custody	Patient discharged/transferred in custody of law enforcement
EX	Extended Care	Patient discharged from acute care setting of hospital, but required sub-acute care in the setting of a convalescent home, board-and-care, etc.
FI	Financial	Decision based on financial status (i.e., cash or self-pay, uninsured)
HP	Health Plan	Health Plan decision
OT	Other	Transfer rationale other than above
RH	Rehab	Patient required rehabilitation
SC	Specialized/ Higher Level Care	Patient required acute specialized care or higher level of care not available at the transferring facility, e.g., pediatrics, burns, complex pelvic fracture, reimplantation

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT FACILITY
- READMIT DISCHARGE CAPACITY

Data Format: [character, 2] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT FACILITY

Definition

If applicable, the three-letter code for the facility to which the patient was transferred following readmission.

Field Values

- See drop-down picklist for all facilities and their codes

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT DISCHARGE CAPACITY

Data Format: [character, 3] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

READMIT DISCHARGE CAPACITY

Definition

Patient's gross functional capacity upon discharge following readmission.

Field Values

LA COUNTY	
H PERMANENT HANDICAP	Limitations from the injury expected to last more than one year
T TEMPORARY HANDICAP	Required ADMISSION to the hospital for injuries sustained
P PRE-INJURY CAPACITY	Discharged FROM THE ED with minimal or no injury

Additional Information

- The null value of *"Not Applicable"* is used if the patient expired.
- A splenectomy in NOT considered a permanent handicap.

Data Source Hierarchy

1. Hospital Discharge Summary
2. Progress Notes
3. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows information to be collected on patient's that are readmitted.

Other Associated Elements

- READMIT DATE
- READMIT TIME
- READMIT COMMENTS
- READMIT COMPLICATIONS
- READMIT DISCHARGE DATE
- READMIT DISCHARGE TIME
- READMIT PRIOR PHASE
- READMIT TRASFERRED / DISCHARGED TO
- READMIT RATIONALE
- READMIT FACILITY

Data Format: [character, 1] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

FINANCES

FINANCES *(Payor)*

Definition

Indicate primary source of payment for patient's hospital care.

Field Values

LA COUNTY	NTDB
Pvt/Commercial Insurance:	
HMO	4 Private/Commercial Insurance
Medi-Cal HMO	4 Private/Commercial Insurance
Other private carrier	4 Private/Commercial Insurance
Auto Insurance	4 Private/Commercial Insurance
Worker's Comp.	8 Workers Compensation
Other Private	10 Other
Medicaid:	
Medi-Cal	1 Medicaid
Medi-Cal pending	1 Medicaid
Medicare (including Medicare HMO)	6 Medicare
Self:	
Cash	3 Self Pay
ATP w/liability	3 Self Pay
Pre-pay	3 Self Pay
Not billed:	
Charity	2 Not Billed (for any reason)
ATP w/o liability	2 Not Billed (for any reason)
Government:	
County Indigent	7 Other Government
CCS (California Children's Services)	7 Other Government
Custody Funds	7 Other Government
VOC (Victims of Crime)	7 Other Government
Other Government	7 Other Government
Organ Donor Subsidy	7 Other Government
Military insurance	7 Other Government

Additional Information

- Field value cannot be *"Not Applicable"*.

Data Source Hierarchy

1. Facesheet
2. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon payor mix.

Other Associated Elements

- TOTAL CHARGES

Data Format: [character, 15] single entry **Picklist:** Yes, non-modifiable
Min Value: N/A **Max Value:** N/A **Accepts Null Value:** Yes

TOTAL CHARGES

Definition

Indicate total of all charges for patient's hospital care.

Field Values

- Relevant value for data element

Additional Information

- Field value cannot be *"Not Applicable"*.

Data Source Hierarchy

1. Billing Sheet / Medical Records Coding Summary Sheet

Uses

- Allows data to be sorted based upon total charges.

Other Associated Elements

- FINANCES *(PAYOR)*

Data Format: [number, 12] single entry **Picklist:** No
Min Value: 0 **Max Value:** 999999999.99 **Accepts Null Value:** Yes

APPENDIX 1:
Reference Guides

REFERENCE GUIDE: Mechanism of Injuries

Incident Type	Code	Code Description (Initial Encounter)
ACCIDENTAL		
Fall		
Fall - struck object	W01.198A	Fall on same level with subsequent striking against other object
Fall - down stairs	W10.8XXA	Fall (on) (from) other stairs and steps
Fall - from bed	W06.XXXA	Fall from bed, initial encounter
Fall - from/off toilet	W18.12XA	Fall from or off toilet with subsequent striking against object
Fall - from cliff	W15.XXXA	Fall from cliff
Fall - from building	W13.8XXA	Fall from, out of or through building or structure
Fall - off chair	W07.XXXA	Fall from chair
Fall - off ladder	W11.XXXA	Fall on and from ladder
Fall - off roof	W13.2XXA	Fall from, out of or through roof
Fall - off sidewalk	W10.1XXA	Fall (on)(from) sidewalk curb
Fall - on ice/snow	W00.0XXA	Fall on same level due to ice and snow
Fall - onto glass	W01.110A	Fall on same level with subsequent striking against sharp glass
Fall - out of window	W13.4XXA	Fall from, out of or through window
Fall - same level	W01.0XXA	Fall on same level without subsequent striking against object
Fall – unspecified fall	W19.XXXA	Fall unspecified
Motorcycle/Motor Vehicle Collision		
MCC - driver vs car	V23.4XXA	Motorcycle driver injured in collision with car, pickup truck or van in traffic accident
MCC - passenger vs car	V23.5XXA	Motorcycle passenger injured in collision with car, pickup truck or van in traffic accident
MCC - driver solo collision	V28.4XXA	Motorcycle driver injured in non-collision transport accident in traffic accident
MVC - bike vs car	V13.4XXA	Pedal cycle driver injured in collision with car, pickup truck, or van in traffic accident
MVC - driver car vs car	V43.52XA	Car driver injured in collision with other type car in traffic accident
MVC - driver car vs object	V47.52XA	Driver of other type car injured in collision with fixed or stationary object in traffic accident
MVC - driver truck vs car	V53.5XXA	Driver of pickup truck or van injured in collision with car, pickup truck or van in traffic accident
MVC - passenger car vs car	V43.62XA	Car passenger injured in collision with other type car in traffic accident

Incident Type	Code	Code Description (Initial Encounter)
MVC - car vs scooter	V98.8XXA	Other specified transport accidents
MVC - pedestrian vs car	V03.10XA	Pedestrian on foot injured in collision with car, pickup truck or van in traffic accident
MVA - skateboard vs car	V03.12XA	Pedestrian on skateboard injured in collision with care, pickup truck or van in traffic accident
Other		
Shot - handgun	W32.0XXA	Accidental handgun discharge
Shot - other gun	W34.00XA	Accidental discharge from unspecified firearms or gun
	INTENTIONAL	
Abuse, Physical - Adult	T74.11XA	Adult physical abuse, confirmed
Assault		
Assault - blunt object	Y00.XXXA	Assault by blunt object
Assault - fists	Y04.0XXA	Assault by unarmed brawl or fight
Assault - human bite	Y04.1XXA	Assault by human bite
Assault - pushed down stairs	Y01.XXXA	Assault by pushing from high place
Assault – struck by car	Y03.0XXA	Assault by being hit or run over by motor vehicle
Shot - BB gun	X95.01XA	Assault by air gun discharge
Shot - hand gun	X93.XXXA	Assault by handgun discharge
Shot - shot gun	X94.0XXA	Assault by shotgun
Shot - unspecified	X95.9XXA	Assault by unspecified firearm discharge
Stabbed - knife	X99.1XXA	Assault by knife
Stabbed - other sharp object	X99.8XXA	Assault by other sharp object
Other		
Cut - self-inflicted	X78.8XXA	Intentional self-harm by other sharp object
Punched through glass	W25.XXXA	Contact with sharp glass
Shot - self-inflicted handgun	X72.XXXA	Intentional self-harm by handgun discharge
	OTHER	
Dog Bite	W54.0XXA	Bitten by dog
Found down	X58.XXXA	Exposure to other specified factors

REFERENCE GUIDE: ED Procedures

Procedure Type	Code	Code Description
Central Line, Upper Vein	05HY33Z	Insertion of Infusion Device into Upper Vein, **Percutaneous**
L External Jugular	05HQ33Z	Insertion of Infusion Device into L External Jugular, **Percutaneous**
R External Jugular	05HP33Z	Insertion of Infusion Device into R External Jugular, **Percutaneous**
L Internal Jugular	05HN33Z	Insertion of Infusion Device into L Internal Jugular, **Percutaneous**
R Internal Jugular	05HM33Z	Insertion of Infusion Device into R Internal Jugular, **Percutaneous**
L Subclavian	05H633Z	Insertion of Infusion Device into L Subclavian, **Percutaneous**
R Subclavian	05H533Z	Insertion of Infusion Device into R Subclavian, **Percutaneous**
Central Line, Lower Vein	06HY33Z	Insertion of Infusion Device into Lower, **Percutaneous**
L Femoral	06HN33Z	Insertion of Infusion Device into L Femoral, **Percutaneous**
R Femoral	06HM33Z	Insertion of Infusion Device into R Femoral, **Percutaneous**
L Saphenous	06HQ33Z	Insertion of Infusion Device into L Saphenous, **Percutaneous**
R Saphenous	06HP33Z	Insertion of Infusion Device into R Saphenous, **Percutaneous**
Chest Tube, L Chest	0W9B30Z	Drainage of L Pleural Cavity, **Percutaneous**
Chest Tube, R Chest	0W9930Z	Drainage of R Pleural Cavity, **Percutaneous**
Cricothyroidotomy	0B110F4 0B113F4 0B114F4	Bypass Trachea with Tracheostomy Device, **Open** Bypass Trachea with Tracheostomy Device, **Percutaneous** Bypass Trachea with Tracheostomy Device, **Percutaneous**, **Endoscopic**
Diagnostic Peritoneal Aspirate (DPA)	0W9G3ZX	Drainage of Peritoneal Cavity, **Percutaneous**, **Diagnostic**
Diagnostic Peritoneal Lavage (DPL)	3E1M38X	Irrigation of Peritoneal Cavity using Irrigating Substance, **Percutaneous**, **Diagnostic**
Endotracheal Intubation	0BH17EZ 0BH18EZ	Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening **Endoscopic**
Intracranial Pressure Monitor (ICP)	4A103BD	Monitoring of Intracranial Pressure, **Percutaneous**
Intraosseous Infusion	3E0A3GC	Introduction of Other Therapeutic Substance into Bone Marrow, Percutaneous Approach
Resuscitative Endovascular Balloon Occlusion of the Aorta (REBOA)	04L03DZ	Occlusion of Abdominal Aorta with Intraluminal Device, **Percutaneous**
Thoracotomy	02JA0ZZ	Inspection of Heart, **Open**

Procedure Type	Code	Code Description
Tracheostomy	0BH10DZ 0BH13DZ 0BH14DZ	Insertion of an Airway into Trachea, **Open** Insertion of an Airway into Trachea, **Percutaneous** Insertion of an Airway into Trachea, **Percutaneous**, **Endoscopic**

REFERENCE GUIDE: Imaging Procedures

Procedure Type	Code	Code Description
ANGIOGROPHY / FLUOROSCOPY		
Abdomen & Pelvis	BW11ZZZ	Fluoroscopy (Angiography) of Abdomen & Pelvis
Head (Intracranial Arteries)	B31RZZZ	Fluoroscopy (Angiography) of Intracranial Arteries
Heart (Right & Left)	B2161ZZ	Fluoroscopy (Angiography) of Right & Left Heart w Low Osmolar Contrast
Carotid Arteries (Common)	B3251ZZ	Fluoroscopy (CT Angiography) of Bilateral Common Carotid Arteries w Low Osmolar Contrast
Cystogram	BT10ZZZ	Fluoroscopy of Bladder
ERCP	BF111ZZ	Fluoroscopy of Biliary & Pancreatic Ducts w Low Osmolar Contrast
Esophagram	BD11ZZZ	Fluoroscopy of Esophagus
Pharyngogram	B91GZZZ	Fluoroscopy of Pharynx & Epiglottis
Upper GI Series	BD15ZZZ	Fluoroscopy of Upper GI
Upper GI w Small Bowel	BD16ZZZ	Fluoroscopy of Upper GI & Small Bowel
Lower Arteries	BN1JZZZ	Fluoroscopy of Other Lower Arteries
Upper Arteries	B31NZZZ	Fluoroscopy of Other Upper Arteries
Vertebral Arteries	B32G1ZZ	Fluoroscopy (CT Angiography) of Bilateral Vertebral Arteries w Low Osmolar Contrast
FOCUSED ASSESSMENT with SONOGRAPHY for TRAUMA (FAST) / ULTRASOUND		
Abdomen & Pelvis	BW41ZZZ	Ultrasonography (FAST) of Abdomen and Pelvis
Pericardium	B24CZZZ	Ultrasonography (FAST) of Pericardium
Carotid Arteries	B345ZZZ	Ultrasonography of Bilateral Common Carotid Arteries
Heart (Right & Left)	B246ZZZ	Ultrasonography of Right and Left Heart
Kidney & Bladder	BT4JZZZ	Ultrasonography of Kidneys and Bladder
Neck Soft Tissue	BW4FZZZ	Ultrasonography of Neck
Lower Extremity	BH48ZZZ	Ultrasonography of Lower Extremity
Lower Extremity Vein	B54DZZZ	Ultrasonography of Bilateral Lower Extremity Veins
Upper Extremity	BH47ZZZ	Ultrasonography of Upper Extremity
Upper Extremity Vein	B54PZZZ	Ultrasonography of Bilateral Upper Extremity Veins
MAGNETIC RESONANCE IMAGING (MRI)		
Brain	B030ZZZ	Magnetic Resonance Imaging of Brain
Head	BW38ZZZ	Magnetic Resonance Imaging of Head
Heart (Right & Left)	B236ZZZ	Magnetic Resonance Imaging of Right & Left Heart

Procedure Type	Code	Code Description
Spinal Cord	B03BZZZ	Magnetic Resonance Imaging of Spinal Cord
PLANAR NUCLEAR MEDICINE IMAGING		
Brain (Cerebral Blood Flow)	C0101ZZ	Planar Nuclear Medicine Imaging of Brain using Technetium 99m (Tc-99m)
Chest	CW131ZZ	Planar Nuclear Medicine Imaging of Chest using Technetium 99m (Tc-99m)
Lungs & Bronchi	CW121ZZ	Planar Nuclear Medicine Imaging of Lungs and Bronchi using Technetium 99m (Tc-99m)

REFERENCE GUIDE: Orthopedic Procedures

Procedure Type	Code	Code Description
Closed Reduction without Internal Fixation (External Approach)		
Left Ankle Dislocation	0SSGXZZ	Reposition Left Ankle Joint
Left Fibula Fracture	0QSKXZZ	Reposition Left Fibula
Left Radius Fracture	0PSJXZZ	Reposition Left Radius
Left Shoulder Dislocation	0RSKXZZ	Reposition Left Shoulder Joint
Left Tibia Fracture	0QSHXZZ	Reposition Left Tibia
Left Ulna Fracture	0PSLXZZ	Reposition Left Ulna
Right Ankle Dislocation	0SSFXZZ	Reposition Right Ankle Joint
Right Fibula Fracture	0QSJXZZ	Reposition Right Fibula
Right Radius Fracture	0PSHXZZ	Reposition Right Radius
Right Shoulder Dislocation	0RSJXZZ	Reposition Right Shoulder Joint
Right Tibia Fracture	0QSGXZZ	Reposition Right Tibia
Right Ulna Fracture	0PSKXZZ	Reposition Right Ulna
External Fixator (Percutaneous Approach)		
Left Fibula w Fracture Reduction	0QSK35Z	Reposition Left Fibula with External Fixation Device
Left Fibula w/o Fracture Reduction	0QHK35Z	Insertion of External Fixation Device into Left Fibula
Left Tibia w Fracture Reduction	0QSH35Z	Reposition Left Tibia with External Fixation Device
Left Tibia w/o Fracture Reduction	0QHH35Z	Insertion of External Fixation Device into Left Tibia
Right Fibula w Fracture Reduction	0QSJ35Z	Reposition Right Fibula with External Fixation Device
Right Fibula w/o Fracture Reduction	0QHJ35Z	Insertion of External Fixation Device into Right Fibula
Right Tibia w Fracture Reduction	0QSG35Z	Reposition Right Tibia with External Fixation Device
Right Tibia w/o Fracture Reduction	0QHG35Z	Insertion of External Fixation Device into Right Tibia
Intramedullary Nail (Percutaneous Approach)		
Left Femur Shaft	0QH936Z	Internal Fixation Device into Left Femoral Shaft
Right Femur Shaft	0QH836Z	Internal Fixation Device into Right Femoral Shaft
Open Reduction with Internal Fixation (Open Approach)		
Left Femur Upper	0QS704Z	Reposition Left Femur Upper
Left Femur Shaft	0QS904Z	Reposition Left Femur Shaft

Procedure Type	Code	Code Description
Left Femur Lower	0QSC04Z	Reposition Left Femur Lower
Left Fibula	0QSK04Z	Reposition Left Fibula
Left Humerus Head	0PSD04Z	Reposition Left Humeral Head
Left Humerus Shaft	0PSG04Z	Reposition Left Humeral Shaft
Left Mandible	0NSV04Z	Reposition Left Mandible
Left Radius	0PSJ04Z	Reposition Left Radius
Left Tibia	0QSH04Z	Reposition Left Tibia
Left Ulna	0QSL04Z	Reposition Left Ulna
Right Femur Upper	0QS604Z	Reposition Right Femur Upper
Right Femur Shaft	0QS804Z	Reposition Right Femur Shaft
Right Femur Lower	0QSB04Z	Reposition Right Femur Lower
Right Fibula	0QSJ04Z	Reposition Right Fibula
Right Humerus Head	0PSC04Z	Reposition Right Humeral Head
Right Humerus Shaft	0PSF04Z	Reposition Right Humeral Shaft
Right Mandible	0NST04Z	Reposition Right Mandible
Right Radius	0PSH04Z	Reposition Right Radius
Right Tibia	0QSG04Z	Reposition Right Tibia
Right Ulna	0QSK04Z	Reposition Right Ulna

REFERENCE GUIDE: Hospital/OR Procedures

Procedure Type	Code	Code Description
Bronchoscopy	0BJ08ZZ	Inspection of Tracheobronchial Tree, Via Natural or Artificial Opening **Endoscopic**
Colectomy	0DBM0ZZ	Excision of Descending Colon, **Open**
Craniectomy	0NB00ZZ	Excision of Skull, **Open**
Craniotomy	00J00ZZ	Inspection of Brain, **Open**
Cystoscopy	0TJB8ZZ	Inspection of Bladder, Via Natural or Artificial Opening **Endoscopic**
Decortification, L Lung	0BDP0ZZ	Extraction of Left Pleura, **Open**
Decortification, R Lung	0BDN0ZZ	Extraction of Right Pleura, **Open**
Dental Wiring	2W31X9Z	Immobilization of Face using Wire
Epidural Catheter	00HU33Z	Insertion of Infusion Device into Spinal Canal, **Percutaneous**
Embolization, Lower Artery	04LY3ZZ	Occlusion of Lower Artery, **Percutaneous**
Embolization, Upper Artery	03LY3ZZ	Occlusion of Upper Artery, **Percutaneous**
Embolization, Splenic Artery	04L43ZZ	Occlusion of Splenic Artery, **Percutaneous**
Endoscopy	0DJ08ZZ	Inspection of Upper Intestinal Tract, Via Natural or Artificial Opening **Endoscopic**
Evacuation of Epidural Hematoma (EDH)	00C30ZZ	Extirpation of Matter from Epidural Space, **Open**
Evacuation of Subdural Hematoma (SDH)	00C40ZZ	Extirpation of Matter from Subdural Space, **Open**
Extracorporeal Membrane Oxygenation (ECMO)	5A15223	Extracorporeal Membrane Oxygenation, Continuous
Exploratory Laparotomy	0WJG0ZZ	Inspection of Peritoneal Cavity, **Open**
Hemodialysis	5A1D00Z	Performance of Urinary Filtration, Single
Intracranial Pressure Monitor (ICP)	4A103BD 4A107BD	Monitoring of Intracranial Pressure, **Percutaneous** Monitoring of Intracranial Pressure, Via Natural or Artificial Opening
Intraoperative Monitoring	4A1034G	Monitoring of Central Nervous Electrical Activity, Intraoperative, **Percutaneous**
Intraventricular Catheter	00H632Z	Insertion of Monitoring Device into Cerebral Ventricle, **Percutaneous**
Inferior Vena Cava (IVC) Filter	06H00DZ 06H03DZ 06H04DZ	Insertion of Intraluminal Device into **Inferior** Vena Cava, **Open** Insertion of Intraluminal Device into **Inferior** Vena Cava, **Percutaneous** Insertion of Intraluminal Device into **Inferior** Vena Cava, **Percutaneous**, **Endoscopic**
Laryngoscopy	0CJS4ZZ	Inspection of Larynx, **Percutaneous**, **Endoscopic**
Lumbar Puncture	009U3ZX	Drainage of Spinal Canal, **Percutaneous**, **Diagnostic**

Procedure Type	Code	Code Description
Packing, Abdominal Wall	2W43X5Z	Packing of Abdominal Wall using Packing Material
Percutaneous Endoscopic Gastrostomy (PEG)	0DH63UZ 0DH64UZ	Insertion of Feeding Device into Stomach, **Percutaneous** Insertion of Feeding Device into Stomach, **Percutaneous**, **Endoscopic**
Percutaneous Endoscopic Jejunostomy (PEJ)	0DHA3UZ	Insertion of Feeding Device into Jejunum, **Percutaneous**
Pericardial Window (Pericardiotomy)	0W9D0ZZ	Drainage of Pericardial Cavity, **Open**
Peripheral Nerve Block	3E0T3CZ	Introduction of Regional Anesthetic into Peripheral Nerves and Plexi, **Percutaneous**
Peritoneal Lavage	3E1M38Z	Irrigation of Peritoneal Cavity using Irrigating Substance, Percutaneous Approach
Repair Abdominal Wall	0WQF0ZZ	Repair Abdominal Wall, **Open**
Repair Bladder	0TQB0ZZ	Repair Bladder, **Open**
Repair Liver	0FQ00ZZ	Repair Liver, **Open**
Repair Stomach	0DQ60ZZ	Repair Stomach, **Open**
Repair Spleen	07QP0ZZ	Repair Spleen, **Open**
Repair L Cardiac Ventricle	02QL0ZZ	Repair Left Ventricle, **Open**
Repair R Cardiac Ventricle	02QK0ZZ	Repair Right Ventricle, **Open**
Small Bowel Resection	0DB80ZZ	Excision of Small Intestine, **Open**
Splenectomy	07TP0ZZ	Resection of Spleen, **Open**
Tracheoscopy	0BJ14ZZ	Inspection of Trachea, **Percutaneous**, **Endoscopic**
Tracheostomy	0BH10DZ 0BH13DZ 0BH14DZ	Insertion of an Airway into Trachea, **Open** Insertion of an Airway into Trachea, **Percutaneous** Insertion of an Airway into Trachea, **Percutaneous**, **Endoscopic**
Ventilator	5A1935Z	Respiratory Ventilation, **Less than 24** Consecutive Hours
Ventilator	5A1945Z	Respiratory Ventilation, **Less than 96** Consecutive Hours
Ventilator	5A1955Z	Respiratory Ventilation, **Equal to or Greater than 96** Consecutive Hours
VAC Abdomen	2W13X6Z	Compression of Abdominal Wall using Pressure Dressing
VAC Chest	2W14X6Z	Compression of Chest Wall using Pressure Dressing
VAC L Lower Leg	2W1RX6Z	Compression of Left Lower Leg using Pressure Dressing
VAC R Lower Leg	2W1QX6Z	Compression of Right Lower Leg using Pressure Dressing
Video-Assisted Thorascopic Surgery (VATS)	0WJQ4ZZ	Inspection of Thorax, **Percutaneous**, **Endoscopic**

APPENDIX 2:
Glossary of Terms

CO-MORBID CONDITIONS

(SPECIAL NOTE: The use of "*Not Applicable*" should NOT be used for this data field. At a minimum, the field value "No NTDS co-morbidities" should be chosen if none of the NTDS' co-morbid conditions listed are present. This value will be mapped to NTDB as *"Not Applicable"*.)

LA COUNTY	NTDB	
No NTDS Co-Morbidities		No NTDS Co-Morbidities are present
Advanced Directive (limiting care) (DNR status)	13	Advanced Directive (limiting care)
Alcoholism	2	Alcohol Use Disorder
Angina (Pectoris)	16	History of Angina within 30 days NTDB RETIRED IN 2017
	32	Angina Pectoris
Anticoagulant Therapy	31	Anticoagulant Therapy
Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)	30	Attention Deficit Disorder/Hyperactivity Disorder (ADD/ADHD)
Bleeding Disorder	4	Bleeding Disorder
Cerebral Vascular Accident (CVA) / Residual Neuro Deficit	10	Cerebral Vascular Accident (CVA)
Chemotherapy (currently receiving)	5	Currently receiving Chemotherapy for cancer
Chronic Obstructive Pulmonary Disease (COPD)	23	Chronic Obstructive Pulmonary Disease (COPD)
Cirrhosis	25	Cirrhosis
Congenital Anomalies	6	Congenital Anomalies
Congestive Heart Failure (CHF)	7	Congestive Heart Failure (CHF)
Current Smoker	8	Current Smoker
Dementia	26	Dementia
Diabetes Mellitus	11	Diabetes Mellitus
Dialysis	9	Chronic Renal Failure
Disseminated Cancer	12	Disseminated Cancer
Drug (Substance) Abuse or Dependence	28	Drug Use Disorder NTDB RETIRED IN 2017
	36	Substance Abuse Disorder
Functionally Dependent Health Status	15	Functionally Dependent Health Status
Hypertension	19	Hypertension
Mental/Personality Disorder	27	Major Psychiatric Illness NTDB RETIRED IN 2017
	33	Mental/Personality Disorder
Myocardial Infarction	17	History of Myocardial Infarction NTDB RETIRED IN 2017
	34	Myocardial Infarction (MI)
Peripheral Arterial Disease (PAD)	35	Peripheral Arterial Disease (PAD)
Prematurity	21	Prematurity
Seizure Disorder	N/A	
Steroid Use	24	Steroid Use
Other:	1	Other
*Ascites (within 30 days) LA RETIRED IN 2017	3	Ascites (within 30 days) NTDB RETIRED IN 2015
*Esophageal Varices LA RETIRED IN 2015	14	Esophageal Varices NTDB RETIRED IN 2015
*Impaired Sensorium LA RETIRED IN 2017	20	Impaired Sensorium NTDB RETIRED IN 2012
*Obesity LA RETIRED IN 2017	22	Obesity NTDB RETIRED IN 2015
*Peripheral Vascular Disease (PVD) LA RETIRED IN 2017	18	Peripheral Vascular Disease (PVD) NTDB RETIRED IN 2017
*Prehospital Arrest with CPR LA RETIRED IN 2015	29	Prehospital Arrest with CPR NTDB RETIRED IN 2015
***NO LONGER AVAILABLE AS PICKLIST OPTIONS**		

Advanced Directive (limiting care): The patient had a Do-Not-Resuscitate (DNR) document or similar advance directive recorded prior to injury.

Alcoholism: Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in the absence of history of abuse.

Angina (Pectoris): (*Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.*) Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of Angina or Chest Pain must be documented in the patient's medical record.

Anticoagulant Therapy: Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Reteplase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenacteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

Attention Deficit Disorder / Hyperactivity Disorder (ADD/ADHD): History of a disorder involving inattention, hyperactivity, or impulsivity requiring medication for treatment.

Bleeding Disorder: (*Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.*) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

Cerebral Vascular Accident (CVA) / Residual Neurological Deficit: A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor, sensory, or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory).

Chemotherapy (currently receiving): A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

Chronic Obstructive Pulmonary Disease (COPD): *Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.)* Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs]).
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of < 75% or predicted on pulmonary function testing.

Cirrhosis: Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

Congenital Anomalies: Documentation of a cardiac, pulmonary, body wall, CNS/spinal, gastrointestinal, renal, orthopedic, or metabolic congenital anomaly.

Congestive Heart Failure (CHF): Inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury. Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue
- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

Current Smoker: A patient who reports smoking cigarettes every day or some days. Exclude patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff).

Dementia: Brain diseases that cause a long term and often gradual decrease in the ability to think and remember such that a person's daily functioning is affected. Pay particular attention to senile or vascular dementia (e.g., Alzheimer's).

Diabetes Mellitus: Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent. Do not include a patient if diabetes is controlled by diet alone.

Dialysis: Renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

Disseminated Cancer: Patients who have cancer that:

- Has spread to one site or more sites in addition to the primary site

AND

- In whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, or bone).

Drug (Substance) Abuse or Dependence: (*Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.)*

Documentation of Substance Abuse Disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

Functionally Dependent Health Status: Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living. Formal definitions of dependency are listed below:

- Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions.
- Totally dependent: The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.

Hypertension: History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record.

Mental / Personality Disorder: (*Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.)* Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

Myocardial Infarction (MI): History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

Peripheral Arterial Disease (PAD): (*Consistent with Centers for Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.*) The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record.

Prematurity: Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

Seizure Disorder (history of): History of a seizure disorder prior to injury that required medication to control.

Steroid Use: Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

HOSPITAL COMPLICATIONS

(SPECIAL NOTE: The use of "*Not Applicable*" should NOT be used for this data field. At a minimum, the field value "No NTDS Complications" should be chosen if none of NTDS' complications listed are present. This value will be mapped to NTDB as *"Not Applicable"*.)

LA COUNTY	NTDB	
No Listed Complications Occurred		No NTDS listed Medical Complications Occurred
Acute Kidney Injury (dialysis)	4	Acute Kidney Injury
Acute Respiratory Distress Syndrome (ARDS)	5	Acute Respiratory Distress Syndrome (ARDS)
Alcohol Withdrawal	13	Drug/Alcohol Withdrawal Syndrome NTDB RETIRED IN 2017
	36	Alcohol Withdrawal Syndrome
Cardiac Arrest with CPR	8	Cardiac Arrest with CPR
Central Line-Associated Bloodstream Infection (CLABSI)	34	Central line-associated bloodstream infection (CLABSI)
Cerebral Vascular Accident (CVA) / Stroke	22	Stroke / CVA
Decubitus (Pressure) Ulcer	11	Decubitus Ulcer NTDB RETIRED IN 2017
	37	Pressure Ulcer
Deep Vein Thrombosis (DVT) / Thrombophlebitis	14	Deep Vein Thrombosis (DVT) /Thrombophlebitis
Extremity Compartment Syndrome	15	Extremity Compartment Syndrome
Myocardial Infarction	18	Myocardial Infarction
Osteomyelitis	29	Osteomyelitis
Pulmonary Embolism (PE)	21	Pulmonary Embolism
Sepsis and/or Severe Sepsis	24	Systemic Sepsis NTDB RETIRED IN 2011
	32	Severe Sepsis
Surgical (Incisional) Site Infection (superficial)	23	Superficial Surgical Site Infection NTDB RETIRED IN 2017
	38	Superficial Incisional Surgical Site Infection
Surgical Site Infection (deep)	12	Deep Surgical Site Infection
Surgical Site Infection (organ/space)	19	Organ/space Surgical Site Infection
Unplanned Intubation	25	Unplanned Intubation
Unplanned Readmission	N/A	
Unplanned Return to the ICU	31	Unplanned Admission to the ICU
Unplanned Return to the OR	30	Unplanned Return to the OR
Urinary Tract Infection Catheter Associated (CAUTI)	33	Catheter-associated Urinary Tract Infection
Ventilator Associated Pneumonia (VAP)	35	Ventilator Associated Pneumonia
Other:	1	Other
*Anastomotic leak LA RETIRED IN 2015	N/A	
*Abdominal Compartment Syndrome LA RETIRED IN 2017	2	Abdominal Compartment Syndrome NTDB RETIRED IN 2011
*Abdominal Fascia Left Open LA RETIRED IN 2017	3	Abdominal Fascia Left Open NTDB RETIRED IN 2011
*Base Deficit LA RETIRED IN 2017	6	Base Deficit NTDB RETIRED IN 2011
*Bleeding LA RETIRED IN 2017	7	Bleeding NTDB RETIRED IN 2011
*Catheter-Related Blood Stream Infection LA RETIRED IN 2017	28	Catheter-Related Blood Stream Infection NTDB RETIRED IN 2016
*Coagulopathy LA RETIRED IN 2017	9	Coagulopathy NTDB RETIRED IN 2011
*Coma LA RETIRED IN 2017	10	Coma NTDB RETIRED IN 2011
*Empyema LA RETIRED IN 2015	N/A	
*Graft / Prosthesis / Flap Failure LA RETIRED IN 2017	16	Graft / Prosthesis / Flap Failure NTDB RETIRED IN 2016
*Increase Intracranial Pressure LA RETIRED IN 2017	17	Increase Intracranial Pressure NTDB RETIRED IN 2011
*Jaundice/Hepatic Failure LA RETIRED IN 2015	N/A	
*Pancreatic LA RETIRED IN 2015	N/A	
*Pneumonia LA RETIRED IN 2017	20	Pneumonia NTDB RETIRED IN 2016
*Urinary Tract Infection (UTI) LA RETIRED IN 2017	27	Urinary Tract Infection (UTI) NTDB RETIRED IN 2016
*Wound Disruption LA RETIRED IN 2017	26	Wound Disruption NTDB RETIRED IN 2011
*Wound Infection LA RETIRED IN 2017	N/A	
***NO LONGER AVAILABLE AS PICKLIST OPTIONS**		

Acute Kidney Injury (dialysis): Abrupt (within 48 hours) reduction of kidney function as defined as:

- Increase in serum creatinine of more than or equal to 3x baseline

OR

- Increase in serum creatinine to ≥4mg/dl (≥353.3µmol/l)

OR

- Patients >18 years with a decrease in $_{e}$GFR to <35 ml/min per 1.73m^2

OR

- Reduction in urine output of <0.3 ml/kg/hr for ≥24 hours

OR

- Anuria for ≥12 hours

OR

- Requiring renal replacement therapy (e.g., continuous renal replacement therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration).

NOTE: If the patient or family refuses treatment (e.g., dialysis) the condition is still considered to be present if a combination of oliguria and creatinine.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration or hemodiafiltration prior to injury.

Acute Respiratory Distress Syndrome (ARDS):

Timing:	Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging:	Bilateral opacities – not fully explained by effusions, lobar/lung collage, or nodules.
Origin of edema:	Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hybrostatic edema if no risk factors present.
Oxygenation:	$200<PaO_2/FiO_2\leq 300$.
(at a minimum)	**AND** Peep or CPAP ≥5 cmH_2O.

Alcohol Withdrawal (Syndrome): (*Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.*) Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record.

Cardiac Arrest with CPR: The sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death.

INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

EXCLUDE patients that arrive at the hospital in full arrest.

Central Line-Associated Bloodstream Infection (CLABSI): A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

AND

A CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access as an inpatient is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line.

Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures

AND

Organism cultured from blood is not related to an infection at another site

Criterion 2: Patient has at least one of the following signs or symptoms:
- fever (>38^{0}C)
- chills
- hypotension

AND

Positive laboratory results are not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements

Criterion 3: Patient ≤ 1 year of age has at least one of the following signs or symptoms:
- fever (>38^{0}C)
- hypothermia
- apnea
- bradycardia

AND

Positive laboratory results are not related to an infection at another site

AND

The same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on the same or consecutive days and separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements.

Cerebral Vascular Accident (CVA) / Stroke: A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:
- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting one side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Or other neurological signs or symptoms consistent with stroke

  AND
- Duration of neurological deficit ≥24 h

OR
- duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

  AND
- No other readily identifiable nonstroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

  AND
- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission).

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.

Decubitus (Pressure) Ulcer: (*Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP*.) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

Deep Vein Thrombosis (DVT) / Thrombophlebitis: The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

Extremity Compartment Syndrome: Condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

Myocardial Infarction (MI): An acute myocardial infarction must be noted with documentation of any of the following:

Documentation of ECG changes indicative of acute MI (one or more of the following three):

- ST elevation >1 mm in two or more contiguous leads
- New left bundle branch block
- New Q-wave in two or more contiguous leads

OR

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

OR

Physician diagnosis of myocardial infarction

Must have occurred during the patient's initial stay at your hospital.

Osteomyelitis: Existence of at least one of the following criteria:

- Organisms cultured from bone.
- Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination.
- At least two of the following signs or symptoms with no other recognized cause:
    - fever (38°C), localized swelling, tenderness, heat, or drainage at suspected site of bone infection and at least one of the following:
        - Organisms cultured from blood
        - Positive blood antigen test (e.g., H. influenzae, S. pneumoniae)
        - Radiographic evidence of infection, e.g., abnormal findings on x-ray, CT scan, magnetic resonance imaging (MRI), radiolabel scan (gallium, technetium, etc.).

Pulmonary Embolism (PE): Lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram.

Sepsis / Severe Sepsis: *(Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.)*

Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.

Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

A diagnosis of Sepsis must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

Surgical Site Infection (SSI) (superficial): (*Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.*) Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)
AND
involves only skin and subcutaneous tissue of the incision
AND
patient has at least ***one*** of the following:

a. purulent drainage from the superficial incision.
b. organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
c. superficial incision that is deliberately opened by a surgeon, attending physician** or other designee and culture or non-culture based testing is not performed.
AND
patient has at least ***one*** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.
d. diagnosis of a superficial incisional SSI by the surgeon or attending physician** or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., C- section incision or chest incision for CBGB)
2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

Surgical Site Infection (deep): (*Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.)* Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to list in Table 2
AND
involves deep soft tissues of the incision (e.g., fascial and muscle layers)
AND
patient has at least ***one*** of the following:

- purulent drainage from the deep incision.
- a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician** or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed.
  AND
  patient has at least ***one*** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.
- an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test.

COMMENTS: There are two specific types of deep incisional SSIs:

1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		

CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

Surgical Site Infection (organ/space): (*Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.)* Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2
AND
infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure
AND
patient has at least ***one*** of the following:

a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

AND
meets at least ***one*** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair		
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic	OVR	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THO	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy

90-day Surveillance	
Code	Operative Procedure
BRST	Breast surgery
CARD	Cardiac surgery
CBGB	Coronary artery bypass graft with both chest and donor site incisions
CBGC	Coronary artery bypass graft with chest incision only
CRAN	Craniotomy
FUSN	Spinal fusion
FX	Open reduction of fracture
HER	Herniorrhaphy
HPRO	Hip prosthesis
KPRO	Knee prosthesis
PACE	Pacemaker surgery
PVBY	Peripheral vascular bypass surgery
VSHN	Ventricular shunt

Table 3. Specific Sites of an Organ/Space SSI.

Code	Site	Code	Site
BONE	Osteomyelitis	LUNG	Other infections of the respiratory
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or
EAR	Ear, mastoid	OREP	Other infections of the male or female
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not	VASC	Arterial or venous infection
IC	Intracranial, brain abscess	VCUF	Vaginal cuff
JNT	Joint or bursa		

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

Unplanned Intubation: Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation.

Unplanned Readmission: Unplanned return to the hospital requiring readmission following initial discharge.

Unplanned Return (admission) to the ICU: Unplanned return to the intensive care unit after initial ICU discharge or admission to the ICU after initial transfer to the floor.

EXCLUDE patients in which the ICU care is required postoperatively for a planned surgical procedure.

Unplanned Return to the OR: Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

Urinary Tract Infection Catheter-Associated (CAUTI): A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1,

AND

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for >2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

Criterion 1:

- *Criterion 1a:* Patient must meet 1, 2, **and** 3 below:
    1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for >2 calendar days, on that date (day of device placement = Day 1)
    2. Patient has at least **one** of the following signs or symptoms:
        - •Fever (>38^{0}C)
        - Suprapubic tenderness with no other recognized cause
        - Costovertebral angle pain or tenderness with no other recognized cause
    3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml.

OR

- *Criterion 1b:* Patient must meet 1, 2, **and** 3 below:
    1. Patient had an indwelling urinary catheter in place for >2 calendar days which was removed on the day of, or day before the date of event
    2. Patient has at least **one** of the following signs or symptoms:
        - Fever (>38^{0}C)
        - Suprapubic tenderness with no other recognized cause
        - Costovertebral angle pain or tenderness with no other recognized cause
        - Urinary urgency with no other recognized cause
        - Urinary frequency with no other recognized cause
        - Dysuria with no other recognized cause
    3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10^5 CFU/ml

Criterion 2: Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
    - fever (>38.0^{0}C)
    - hypothermia (<36.0^{0}C)
    - apnea with no other recognized cause
    - bradycardia with no other recognized cause
    - lethargy with no other recognized cause
    - vomiting with no other recognized cause
    - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10^5 CFU/ml.

Pneumonia Ventilator-Associated: A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1

AND

The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.

VAP ALGORITHM (PNU2 BACTERIAL OR FILAMENTOUS FUNGAL PATHOGENS):

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old **NOTE:** In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.	At least **one** of the following: • Fever (>38^{0}C or >100.4^{0}F) • Leukopenia (<4000 WBC/mm^3)or leukocytosis (≥12,000WBC/mm^3) • For adults ≥70 years old, altered mental status with no other recognized cause **AND** at least two of the following: ○ New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements ○ New onset or worsening cough, or dyspnea, or tachypnea ○ Rales or bronchial breath sounds ○ Worsening gas exchange (e.g.,0_2 desaturations (e.g., PaO_2/FiO_2≤240), increased oxygen requirements, or increased ventilator demand)	At least **one** of the following: • Positive growth in blood culture not related to another source of infection • Positive growth in culture of pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least **one** of the following evidences of pneumonia: ○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli ○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae

VAP ALGORITHM (PNU2 VIRAL, LEGIONNELLA, AND OTHER BACTERIAL PNEUMONIAS):

Radiology	Signs/Symptoms	Laboratory
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old	At least **one** of the following: • Fever (>38^{0}C or >100.4^{0}F) • Leukopenia (<4000 WBC/mm^3) or leukocytosis (≥12,000WBC/mm^3) • For adults ≥70 years old, altered mental status with no other recognized cause **AND** at least two of the following:	At least **one** of the following: • Positive culture of virus, Legionella or Chlamydia from respiratory secretions • Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus,Bordetella, Chylamydia, Mycoplasma, Legionella (e.g.,

NOTE: In patients **without** underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable.

- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnea, or tachypnea
- Rales or bronchial breath sounds
- Worsening gas exchange (e.g.,0_2 desaturations (e.g.,$PaO_2/FiO_2 \leq 240$), increased oxygen requirements, or increased ventilator demand)

EIA<FAMA< shell vial assay, PCR,micro-IF)

- Fourfold rise in pared sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)
- Fourfold rise in L. pneumophila serogroup 1 antibody titer to ≥1:128in pared acute and convalescent sera by indirect IFA
- Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR INFANT'S ≤1 YEAR OLD:

Radiology	Signs/Symptoms
Two or more serial chest radiographs with at least **one** of the following: • New or progressive **and** persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1year old NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable	Worsening gas exchange (e.g., O_2 desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) **AND** at least **three** of the following: • Temperature instability • Leukopenia (<4000 WBC/mm³) **or** leukocytosis (≥15,000WBC/mm³) and left shift (≥10% band forms) • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting • Wheezing, rales, or rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)

VAP ALGORITHM ALTERNATE CRITERIA (PNU1), FOR CHILDREN >1 YEAR OLD OR ≤12 YEARS OLD:

Radiology	Signs/Symptoms/Laboratory
Two or more serial chest radiographs with at least **one** of the following:	At least **three** of the following: • Fever (>38.0^{0}C or >100.4^{0}F) or hypothermia (<36.0^{0}C or <96.8^{0}F)

- New or progressive **and** persistent infiltrate
- Consolidation
- Cavitation
- Pneumatoceles, in infants ≤1year old

NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), **one definitive** chest radiograph is acceptable

- Leukopenia (<4000 WBC/mm^3) **or** leukocytosis (≥15,000WBC/mm^3)
- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnea, apnea, or tachypnea
- Rales or bronchial breath sounds
- Worsening gas exchange (e.g., O_2 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand

OTHER TERMS

Dead on arrival (DOA): DOA is defined as arrival at the hospital with no signs of life, but with pre-hospital CPR as indicated below:

- Age >12 years
  - Blunt trauma, more than 5 minutes pre-hospital CPR
  - Penetrating head/neck/abdomen trauma, more than 5 minutes pre-hospital CPR
  - Penetrating chest trauma, more than 15 minutes pre-hospital CPR
- Age ≤ 12 years
  - Blunt trauma, more than 15 minutes pre-hospital CPR
  - Penetrating trauma, more than 15 minutes pre-hospital CPR

Operative and/or essential procedures is defined as procedures performed in the Operating Room, Emergency Department, or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries. Repeated diagnostic procedures (e.g., repeated CT scan) should not be recorded (record only the first procedure.

INJURY DESCRIPTIONS

INJURY DESCRIPTION	
14	GCS ≤**14**: Blunt force head injury associated with a Glasgow Coma Scale score of less than or equal to 14. Code may also be used when a strong index of suspicion for blunt head injury exists due to mechanism of injury and/or signs or symptoms such as seizures, unequal pupils, or focal neurological deficits
90	SBP <**90** (<70 if under 1y): Systolic blood pressure less than 90mmHg in a patient greater than one year of age (or systolic blood pressure less than 70mmHg in a patient less than one year of age) following a traumatic event
BA	**B**lunt **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to blunt force
BB	**B**lunt **B**ack: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to blunt force
BC	**B**lunt **C**hest: Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to blunt force
BD	**B**lunt **D**iffuse Abdominal Tenderness: Blunt force injury to the abdomen resulting in tenderness in two or more quadrants
BE	**B**lunt **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to blunt force
BF	**B**lunt **F**ace/mouth: Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to blunt force
BG	**B**lunt **G**enitals: Injury to the external reproductive structures due to blunt force
BH	**B**lunt **H**ead: Injury to the head or skull in the area from above the eyebrows to behind the ears, due to blunt force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
BI	**B**lunt Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to blunt force
BK	**B**lunt Buttoc**K**s: Injury to the buttocks due to blunt force
BL	**B**lunt Minor **L**acerations: Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to blunt force
BN	**B**lunt **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to blunt force
BP	**B**lunt Tension **P**neumothorax: Air enters the pleural space due to blunt force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
BR	**B**lunt F**R**acture of 2 or more long bones: Blunt force injury resulting in apparent fracture of 2 or more proximal long bones (humerus, femur)
BT	**B**lunt **T**rauma Arrest: Cessation of cardiac output and effective circulation due to blunt force
BU	**BU**rns/Elec. Shock: Thermal or chemical burn, or electric shock
BV	**B**lunt extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to blunt force
FC	**F**lail **C**hest: Blunt force injury to the chest wall resulting in an unstable chest wall, characterized by paradoxical chest wall movement with respirations

INJURY DESCRIPTION	
IT	**I**npatient **T**rauma: Interfacility transfer (IFT) of an admitted, injured patient from one facility to an inpatient bed at another facility, excluding ER to ER transfers
NA	**N**o **A**pparent Injury: No complaint, or signs or symptoms of injury following a traumatic event
PA	**P**enetrating **A**bdomen: Injury to any of the abdominal quadrants, flanks, or pelvis due to penetrating force
PY	**P**enetrating Back: Injury to the area from the shoulders to the buttocks (but not including the buttocks) due to penetrating force
PC	**P**enetrating **C**hest: Injury to the anterior chest in the area between the clavicle and the xyphoid process, bordered on either side by the posterior axillary line, due to penetrating force
PE	**P**enetrating **E**xtremities: Injury or pain to the shoulders, arms, hands, legs, or feet due to penetrating force
PF	**P**enetrating **F**ace/mouth: Injury to the anterior aspect of the face, mouth, or skull, from and including the eyebrows, down to and including the angle of the jaw and the ears, due to penetrating force
PG	**P**enetrating **G**enitals: Injury to the external reproductive structures due to penetrating force
PH	**P**enetrating **H**ead: Injury to the head or skull in the area from above the eyebrows to behind the ears, due to penetrating force. This code can also be applied in association with facial injuries when it is likely that the brain is involved
PI	**P**enetrating Amputat**I**on: Amputation proximal to (above) the wrist or ankle due to penetrating force
PK	**P**enetrating Buttoc**K**s: Injury to the buttocks due to penetrating force
PL	**P**enetrating Minor **L**acerations (Penetrating): Superficial or non-serious lacerations, abrasions, or contusions involving the skin or subcutaneous tissue, due to penetrating force
PN	**P**enetrating **N**eck: Injury or pain to the area between the angle of the jaw and clavicles (including probable cervical spine injuries) due to penetrating force
PP	**P**enetrating Tension **P**neumothorax: Air enters the pleural space due to penetrating force, and creates pressure on chest organs. Signs and symptoms can include: SOB, tachypnea, decreased or absent lung sounds on one side, shock, neck vein distention, and/or tracheal deviation
PT	**P**enetrating **T**rauma Arrest: Cessation of cardiac output and effective circulation due to penetrating force
PV	**P**enetrating extremity injury with neurological and/or **V**ascular compromise, or one that is crushed, degloved, or mangled due to penetrating force
PX	Penetrating e**X**tremity injury proximal to (above) the knee or elbow due to penetrating force
RR	**RR** <10/>29 (<20 if <1y): A sustained respiratory rate greater than 29 breaths/minute, or respiratory rate of less than 10 breaths/minute (or less than 20 breaths/minute in a patient less than one year of age), following a traumatic event
SC	**S**pinal **C**ord Injury: Suspected spinal cord injury, or presence of weakness/paralysis/parasthesia following a traumatic event
SX	**S**uspected Pelvic Fracture: Suspected pelvic fracture, e**X**cluding isolated hip fractures from a ground level fall

MECHANISM OF INJURY

MECHANISM OF INJURY (MOI)	
15	Fall >**15** ft. (>10 ft. Peds): A vertical, uninterrupted fall of >15 feet for an adult or >10 feet or 3 times the height of the child for a pediatric patient. This mechanism is a subcategory of "Fall." This does not include falling down stairs or rolling down a sloping cliff.
18	Intrusion of >**18** inches into an unoccupied passenger space
20	An unenclosed transport crash (e.g., skateboard, bicycle, horse) with an estimated impact of >**20** mph, not involving a moving auto
AN	**AN**imal Bite: The teeth of a human, reptile, dog, cat, or other animal inflicted an injury, whether or not the skin was punctured.
AS	**AS**sault: Patient was physically assaulted (kicked, punched, strangled, etc.) by means other than stabbing or shooting
CR	**CR**ush: Injury sustained as the result of external pressure being placed on body parts between two opposing forces
EJ	**EJ**ected: Patient was fully or partially thrown from a vehicle, including convertibles and trucks. Does NOT include motorcycles
ES	**E**lectrical **S**hock: Passage of an electrical current through body tissue as a result of contact with an electrical source
EV	**E**nclosed **V**ehicle: Patient involved in collision while in an enclosed vehicle, such as a an automobile, bus, or other enclosed motorized vehicle
EX	**EX**trication: Use of a pneumatic tool was required to remove patient from the vehicle
FA	**FA**ll: Any injury resulting from a fall from any height
GS	**G**un**S**hot Wound (GSW): Injury was caused by discharge of a gun (accidental or intentional)
MM	**M**otorcycle/**M**oped: The patient was riding on a motorcycle or moped at the time of impact; code should be used whenever a motorcycle or moped is involved, other codes may apply (e.g. 20, RT, or PB)
OT	**OT**her: A cause of injury that does not fall into any of the existing categories
PB	**P**edestrian/**B**icyclist/motorcyclist is struck by a motorized vehicle who is NOT thrown or run over, and impact is estimated to be ≤20 MPH
PS	**P**assenger **S**pace Intrusion: Intrusion of >**12** inches into an occupied passenger space of a motor vehicle
RT	Moving auto vs. pedestrian/bicyclist/motorcyclist: **R**un over, **T**hrown, or with an estimated impact of >20 MPH
SA	**S**elf-Inflicted, **A**ccidental: The injury appears to have been accidentally caused by the patient
SF	**S**urvived **F**atal Accident: The patient survived a collision where another person in the same vehicle was fatally injured
SI	**S**elf-Inflicted, **I**ntentional: The injury appears to have been intentionally caused by the patient
SP	**SP**orts/Recreation: Any injury that occurs during a sporting or recreational athletic activity, such as aerobics, football, jogging, etc.
ST	**ST**abbing: A sharp or piercing instrument (e.g. knife, broken glass, ice pick, etc.) was used to cause an injury which penetrated the skin
TB	**T**hermal **B**urn: Burn caused by heat
TD	**T**elemetry **D**ata: Vehicle telemetry data that is consistent with high risk of serious injury
UN	**UN**known: The cause or mechanism of injury is unknown
WR	**W**ork-**R**elated: Injury occurred while patient was working, and may be covered by Worker's Compensation

APPENDIX 3:
Auto-calculated Variables

Abbreviated Injury Scale (six body regions)

Definition: The Abbreviated Injury Scale (AIS) is an anatomical scoring system first introduced in 1969. Since this time it has been revised and updated against survival to provide a ranking the severity of injury. AIS scores are available for six body regions; Head (or neck), Face, Chest, Abdominal, Extremities (including pelvis) and External. The AIS is monitored by a scaling committee of the Association for the Advancement of Automotive Medicine.

Calculation: Injuries are ranked on a scale of 1 to 6, with 1 being minor, 5 severe and 6 an un-survivable injury. This represents the 'threat to life' associated with an injury and is not meant to represent a comprehensive measure of severity. The AIS is not a true scale, in that the difference between any two AIS scores is not the same as the difference between another set of two scores.

FIPS code (location code)

Definition: Federal Information Processing Standards codes (FIPS codes) are a standardized set of numeric codes issued by the National Institute of Standards and Technology (NIST) to ensure uniform identification of geographic entities. The entities covered include: states, counties, cities and other statistically equivalent entities.

Calculation: An overall FIPS code is calculated by concatenating individual FIPS codes for state (2-digit FIPS code), county (3-digit FIPS code) and city (5-digit FIPS code) in that order.

Injury Severity Score

Definition: The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries.

Calculation: Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis) and External). The 3 most severely injured body regions have their AIS score squared and added together to produce the ISS score. Only the highest AIS score in each body region is used. The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (un-survivable injury), the ISS score is automatically assigned to 75.

Overall GCS - EMS score (adult and pediatric)

Definition: A scale calculated in the out-of-hospital setting which evaluates the patient's initial level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

Calculation: Initial Field GCS Eye + Initial Field GCS Verbal + Initial Field GCS Motor

Overall GCS - ED score (adult and pediatric)

Definition: A scale calculated in the emergency department (ED) or hospital setting which evaluates the patient's initial (upon arrival) level of awareness, which indirectly indicates the extent of neurologic injury. The score is based upon three categories of patient responses; eye opening, verbal response, and motor response. The lowest score is 3 and is indicative of no response, the highest score is 15, indicates the patient is alert and aware of his or her surroundings.

Calculation: Initial ED/Hospital GCS Eye + Initial ED/Hospital GCS Verbal + Initial ED/Hospital GCS Motor

Revised Trauma Score - EMS (adult and pediatric)

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the out-of-hospital setting.

Calculation: RTS = 0.9368 (Initial Field GCS Total) + 0.7326 (Initial Field Systolic Blood Pressure) + 0.2908 (Initial Field Respiratory Rate)

Revised Trauma Score - ED (adult and pediatric)

Definition: The Revised Trauma Score is a physiological scoring system used to predict death from injury or need for trauma center care. It is scored based upon the initial vital signs obtained from the patient in the ED or hospital setting

Calculation: RTS = 0.9368 (Initial ED/Hospital GCS Total) + 0.7326 (Initial ED/Hospital Systolic Blood Pressure) + 0.2908 (Initial ED/Hospital Respiratory Rate)

Total ED Time

Definition: The total elapsed time the patient was in the emergency department (ED).

Calculation: ED Discharge Date/Time – ED/Hospital Arrival Date/Time

Total Length of Hospital Stay

Definition: The total elapsed time the patient was in the hospital.

Calculation: Hospital Discharge Date/Time – ED/Hospital Arrival Date/Time

Trauma Injury Severity Score (TRISS)

Definition: The Trauma Injury Severity Score (TRISS) determines the probability of survival (Ps) of a patient based upon the patient’s age, type of injury (blunt versus penetrating), the Injury Severity Score (ISS), and the Revised Trauma Score (RTS).